NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

John Fawkner Private Hospital

COBURG, VIC

Organisation Code: 220189
Health Service Facility ID: 101268
Assessment Date: 6-9 December 2021

Accreditation Cycle: 1

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Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

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

A rating report is provided for each health service facility.

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

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

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

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

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

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low. Risk ratings are:

1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: low risk; manage by routine procedures

Executive Summary

John Fawkner Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 6/12/2021 to 9/12/2021. The NS2 OWA required three assessors for a period of four days. John Fawkner Private Hospital is a private health service and was last assessed on 19-21/03/2018.

John Fawkner Private Hospital (JFPH) is a private hospital in Melbourne's inner north. It has a medical/surgical and oncology casemix with imaging services including an angiography suite augmented by an Emergency Department managed by a contracted VMO FACEM team and a Critical Care Complex which provides high level care to patients undergoing major surgery and other medical conditions. It is very well supported by Healthscope (HSP) which is increasingly standardising its processes to ensure consistency of safety and quality across the entire organisation. Hospital performance is monitored locally and reported via key performance indicators across an expansive range of indicators, to the HSP Board. Assessors note a new and enthusiastic leadership team is now in place, committed to maintaining a well-managed, safe organisation within a culture of continuous quality improvement.

Assessors noted that the hospital is currently not functioning to full capacity because of legislative requirements to reduce surgical services in order for the state of Victoria to cope with high numbers of Covid patients. Further note was made of the excellent response made by JFPH when several aged care residents, some infected with COVID-19 were unexpectedly transferred to the hospital for care.

The organisation's risk management and quality frameworks are robust and the attention to quality and safety is much in evidence. JFPH clearly understands the importance of audit and evaluation which have led to ongoing quality improvement across the eight National Standards in Version 2 and assessors note the support provided by Healthscope corporate to achieve the levels of monitoring and high-quality outcomes observed.

In preparation for assessment, the organisation provided very comprehensive pre-assessment documentation. On site, assessors visited all clinical areas, met with the JFPH leadership team and numerous clinical and non-clinical staff. Assessors also met with the current Chair of the Medical Advisory Committee and three MAC members. Assessors had easy access to policies, procedures and extensive documentation. Assessors also spoke to many patients, who all felt actively involved in their care, and well cared for during their admission. Assessors completed several patient and process journeys to learn more about the hospital's safety systems and ran a number of high-risk scenarios past staff. All staff involved were able to articulate processes in place to deal with such scenarios.

Assessors also had the opportunity to observe the organisation's responsiveness to emerging issues when some adaptations were required to medication safety during the assessment period.

A synopsis of the eight standards is now provided:

JFPH has robust governance with the active support of HSP through its policies, procedures and monitoring procedures. Risks are closely monitored and managed. There is a strong commitment to patient-centred care and partnering with consumers.

Quality improvement is embedded, aligned with forcing factors such as action plan reviews. Staff are trained in safety and quality and understand their roles in this regard. Management of credentialling and scope of practice is meticulous and evidence-based care is being given increasing priority. It was pleasing to see clinical indicators monitored, as well as implementation of relevant ACSQH Clinical Care Standards. A safe environment is maintained. Aboriginal patients are respectfully and sensitively cared for and offered access to local Aboriginal support services if they wish.

There is a strong focus on partnering with consumers. The consumer consultants are very enthusiastic about their roles and each one is allocated to a different range of areas. They participate in a range of activities at the ward level and within the committee structure. The ‘Back to Bedside’ program has provided a stronger focus on patients and some new initiatives. Patients are encouraged to provide feedback and reported that were happy with the service that they receive.

Infection control is very well managed and JFPH is very well supported by Healthscope and HICMR from both a policy and procedural perspective and through on-site activities. Assessors observed meticulous cleaning, use of PPE and hand hygiene. Staff are well trained in all aspects of infection control. An active immunisation and staff health program ensures vaccination rates stay high. The new operating theatres and CSSD have meant that the hospital is almost fully compliant with AS4187-14 except for a few areas such as the Endoscope cleaning room which is awaiting capital expenditure.

Antimicrobial stewardship is robust and clinicians are increasingly mindful of their obligations in this regard.

Medication safety is generally well managed with good governance which includes a comprehensive suite of policies and procedures. HPS Pharmacies provide the pharmacy services. A suite of audits provides information, with actions being implemented as a result of these. There is safe and secure storage and distribution of medicines, and a strong focus on high-risk medicines. There are suggestions for strengthening some of the clinical activities including obtaining the best possible medication history, and documentation of medication reconciliation and adverse drug reactions.

Comprehensive Care is very well done at JFPH. There is a very comprehensive screening tool to identify any conditions that may put the patient at risk of complications during their stay in hospital. Positive screening leads to referrals to the most appropriate services within the first 24 hours which provides early intervention to any clinical risks the patient may be subject to. Surprisingly, JFPH also includes screening for Venous Thrombo-Embolus (VTE) which is a very intelligent inclusion, particularly for high-risk surgical orthopaedic cases. The comprehensive care plan identifies the patient’s goals/aspirations and staff always involve both the family and their family/carer with its monitoring and development over the stay within the organisation.

In addition, discharge planning starts on the day of admission, so everyone involved understands what needs to be done to get the discharge completed on time.

Communicating for Safety is another area that is done well at JFPH. Patients are always identified using at least three unique identifiers and procedure matching is conducted both for medication and investigations, but also in the operating suite, with a Team Time-Out.

Clinical handover is facilitated by the ISBAR methodology and is conducted bed-to-bed by the exiting and commencing shifts at all times. This is all part of the "Back to the Bedside Program" which is another very good program to ensure great communication with both the patient and their family/carer, but also at least hourly checks on all patients in an effort to provide opportunistic toileting and other services for patients such as opening small packs related to their meals. Critical information is all placed on the Alert Sheet which sits right at the front of the Medical Record to highlight the most important information related to the patient.

Blood is well managed with comprehensive policies and protocols, with records being well documented. Redesign of the Blood and Blood Products prescription and Transfusion Record has resulted in succinct, comprehensive information being available on the one page. Two pathology providers are co-located with the hospital. A Massive Transfusion Resource Folder was introduced in 2020. Strategies have been put in place to optimise patients' blood requirements. Emergency supplies are rotated by the private pathology provider for use elsewhere keep wastage to a minimum.

The management of acute deterioration, whether physiological or cognitive/mental health related, is also done very well at JFPH. The staff of the CCC and ED supported by Intensivists and FACEMs run a 24/7 Code Blue and MET Call Service to respond to staff/patient/family concern in a patient's condition in any part of the hospital. These staff that respond in such situations are very well trained and support and encourage ward staff to not only participate but mentor them through what can be very stressful situations. Mental health deterioration is much less common but there are many benefits for JFPH being part of Healthscope with close links to two private mental health facilities to support them. Management of delirium and cognitive impairment is also done well.

In conclusion assessors noted that JFPH staff were uniformly very proud of their organisation and have numerous opportunities for education, training and professional development, where compliance in mandatory training is very high. It is obvious that John Fawkner Private Hospital has worked very hard and there has been steady improvement in systems and processes associated with the eight National Standards, despite the turmoil created by now nearly two years of COVID-19 pandemic.

JFPH is to be congratulated on the way it managed the unexpected transfer of many fragile, elderly residents when the aged care facility in which they resided was forced to close due to a massive Covid outbreak, providing expert care, a high degree of compassion and outstanding infection control which saw minimal spread of disease amongst patients or staff.

Assessors have rated all actions as Met – without recommendations.

Summary of Results

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

Sites for Assessment
John Fawkner Private Hospital

Site	HSFID	Address	Visited
John Fawkner Private Hospital	101268	275 Moreland Road COBURG VIC 3058	Yes

Standard 1 - Clinical Governance

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

ACTION 1.1
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
John Fawkner Private Hospital (JFPH) is one of 44 Healthscope (HSP) hospitals throughout Australia. The Healthscope Board (along with the Healthscope Advisory Board which provides expert clinical guidance to the Board) demonstrates a high-level commitment to the maintenance of a safety and quality improvement culture from which JFHP benefits through extensive policy support and a robust monitoring framework. Safety and quality are led by the Board sub-committee, the Clinical Quality Committee which considers all hospitals' quality and safety outcomes including the review of action plans where outcomes do not meet established benchmarks. The OneHealthscope 2025 Strategy makes clear HSP's commitment to safety and quality through its platforms to improve the human experience (for patients, workforce, and partners) and its investment in infrastructure. This has been developed through extensive consultation and is now widely communicated to all stakeholders via a range of hard copy and electronic mechanisms. The Strategy was much in evidence at JFPH. The commitment to partnering with patients, carers and consumers is obvious, with consumers active participants on all relevant committees at both local hospital and corporate levels. There is an extensive network of feedback mechanisms to obtain, and act on, consumer perspectives replicated across all hospital sites in which the Board takes great interest. Consumer partnership is described in policy to assist hospitals to meet their obligations in this regard. The governing body has a clinical governance framework which informs all hospital clinical governance plans, including that of JFPH's. All are formally endorsed. As stated, a robust monitoring framework is in place whereby hospitals report monthly against an established set of quality and safety performance indicators, which are compared to benchmarks. Any deviation from benchmarks requires explanation and an action plan which is monitored closely by the Healthscope Clinical Quality Committee. The monitoring process includes assurance that roles and responsibilities of all HSP employees are clearly defined and regularly reviewed. A comprehensive committee structure provides a pathway for monitoring actions taken as a result of analysis of clinical incidents. All sentinel events are reported immediately to the HSP Chief Executive Officer (CEO) who informs the Board in a timely way if required.

Org Name : John Fawkner Private Hospital
Org Code : 220189

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Rating	**Applicable HSF IDs**
Met	All

ACTION 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
HSP is committed to addressing the needs of Aboriginal and Torres Strait Islander people through the establishment of safety and quality priorities. It has developed the Aboriginal and Torres Strait Islander Engagement Plan 2021 monitored by the Reconciliation Working Group. The Engagement Plan forms the basis for all related local hospital initiatives including those at JFPH. All Healthscope staff undertake mandatory on-line learning related to cultural competence and HSP has significant resources available on HINT to support strategies to improve ATSI health and wellbeing. JFPH acknowledges its location on the land of the Wurundjeri people of the Kulin nation which is disputed territory. The hospital has engaged with the local Aboriginal health cooperative Merri Health to partner with it in meeting patient needs and relationships are strengthening. Its activities in this regard are tracked by the governing body through performance indicators related to the Engagement Plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
JFPH has a comprehensive clinical governance process maintained in accordance with its obligations to the parent company Healthscope (HSP) whose overarching clinical governance framework sets out the requirements for each of its 44 hospitals. The Clinical Governance Framework guides JFPH in those systems in place which measure and monitor the safety and quality process and includes systems of control such as robust reporting requirements with defined performance indicators benchmarked against peer hospitals in the group, and comprehensive reviews of clinical incidents, particularly those which meet the criteria for Healthscope defined sentinel events. Accompanying this monitoring process is company-wide Shared Learnings Program, whereby all relevant hospitals must demonstrate that learnings from serious events at like hospitals are applied at their own – avoiding or mitigating risks which may not previously have been identified. The HSP Quality and Risk Plan ensures HSP incorporates healthcare safety and quality into its business decision making, being aligned to the Healthscope Strategic Plan. All JFPH's quality and safety initiatives reflect this process in its own local Clinical Governance Safety and Quality and Strategic Plans. JFPH must submit quarterly clinical Quality Key Performance Indicators (KPIs) to HSP for review by the Clinical Quality Committee with key issues added to the Executive and Board agendas as required. Healthscope strategic planning ensures meaningful partnerships with consumers occurs. A newly formed National MAC (Medical Advisory Committee) has been developed to advise on issues relating to medical governance, an initiative which should strengthen the current Clinical Governance Framework. The current chair of the JFPH MAC has been appointed as a member of the inaugural National MAC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
Assessors were provided with evidence that JFPH continues to monitor the strategies in place to meet the very small percentage of those patients currently identifying as Aboriginal and Torres Strait Islander people through strengthening relationships with local Aboriginal NGOs. NAIDOC Week is celebrated as is National Reconciliation Week. Fundraisers support aboriginal literacy. High numbers of staff have completed cultural awareness and competence training and have created a welcoming environment for Aboriginal consumers, led by the HSP Board.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
JFPH considers the safety and quality of patient's health care in business decision making aligned to the Healthscope Quality and Risk Plan and the JFPH Safety and Quality and Strategic Plans. Examples of this were provided to assessors and are reflected in the hospital's facilities such as the new Intensive Care Unit, Emergency Department, Operating Suite and surgical wards. Such initiatives have been implemented using the consumer experience to improve care and services and to deliver safe and effective care and services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
It was evident to assessors that the JFPH Executive team has a strong commitment to safety and quality, supporting clinicians to perform their safety and quality roles and responsibilities. Safety and quality information is highly visible throughout the organisation and underpins the training/education program. Assessors met with the leadership team, managers, clinical staff and patients, and through conversations with them, and review of an extensive range of safety and quality documentation were satisfied of this. In compliance with HSP human resources and safety/quality policy JFPH has position descriptions for the workforce which includes responsibility for quality and safety based on the corporate template. These are recorded and tracked in conjunction with staff performance reviews. Medical Officers are bound by Healthscope Bylaws 2019. These Bylaws assist VMOs to operate within a clinical governance framework which is monitored through the Medical Advisory Committee and craft group meetings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.7
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Comments
HSP has an extensive range of standardised policies by which JFPH is governed, and with which it must comply. Included in the system is a process whereby if Healthscope policy is not available a local policy/standard operating procedure (SOP) can be developed provided it meets HSP criteria. In regard to infection control, HSP is guided by a private company (HICMR) whose policies comprehensively oversight infection control at JFPH. The Healthscope Document Controller maintains the policy review process and monitors for legislative, regulatory and jurisdictional compliance. The Document Controller issues new or updated policies monthly with these distributed throughout the hospital by the JFPH Quality Manager. In 2020 Healthscope listed its high-risk policies with compliance audited via incident review, near misses and feedback.

ACTION 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
An example of a risk management approach was provided whereby during the first months of the Covid pandemic multiple related policies with frequent amendments were being distributed by the jurisdiction. To ensure that staff kept abreast of, and complied with these many changes, all other policies coming up for renewal were risk assessed and review delayed where this could safely occur. Compliance with policies is measured through an extensive audit framework (where levels of compliance are generally high) and through analysis of all incidents to identify policy breaches and effect change through well-monitored action plans.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.8
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems
Comments
An effective system is in place to use organisation-wide quality improvement systems. Healthscope sets lofty expectations in regard to safety and quality, defining priorities through its strategic planning and creating a rigorous framework for measuring, monitoring and reporting on performance and outcomes. JFPH complies with corporate policy through monthly data uploads to the corporate Clinical Governance (CG) team. The CG team reviews the hospital's data and formats it into the reporting template which contains benchmarked targets. Deviations from benchmark require an action plan from JFPH which is monitored by the CG team. Several examples of how this process functions were provided to assessors. Assessors also observed how JFPH 's action plans are put into place through its relevant committees (such as the Infection Control Committee and the Medication Safety Committee) and monitored by the Clinical Governance Committee. This process assists clinical staff to make required improvements and to measure their effects through the local audit process.

ACTION 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
JFPH uses other mechanisms to monitor quality improvements in addition to required performance indicators. It carefully analyses incidents reported through RiskMan, the incident management system, for trends and improvement opportunities as well as reviewing patient/consumer feedback. If issues are identified they are subject to the same monitoring process through action plans. Consumers are represented on the JFPH Clinical Governance Committee to provide clinicians with a consumer perspective of improvements required which has led to several changes described to assessors in evidence. When this was tested with nursing staff, they were able to articulate many examples of local quality improvement initiatives including some at ward level. Many of these were on display on Safety and Quality Boards throughout the organisation in patient and non-clinical areas for wide dissemination.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.9
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations
Comments
A comprehensive reporting framework for matters relating to safety and quality systems is in place across all HSP hospitals in accordance with policy. Outcomes are benchmarked against like hospitals so that shared learnings can be used to improve performance. All reporting on safety and quality is timely and reports are provided to the HSP governing body through its sub-committee, the Clinical Quality Committee. Consumers are also represented on the Healthscope Clinical Quality Committee and are members of the local committee at JFPH. Safety and Quality Boards located in public areas for consumers to read provide a mechanism for feeding back to patients. Consumers, and other relevant health service organisations can also easily access safety and quality outcomes via the MyHealthscope website. There is an extensive range of quality and safety items/reports discussed at ward/departmental meetings, at craft group meetings and at the hospital's committees. The Medical Advisory Committee (MAC) also reviews outcomes and is a platform to keep Visiting Medical Officers (VMO) up to date with the hospital's performance across its many indicators The MAC at JFPH is particularly engaged, taking great interest in safety and quality, as it relates to care provided by medical practitioners.

ACTION 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
The hospital sends data to a number of sources where it participates in external benchmarking and receives reports in return. These include VICNISS (Infection Control) and ANZIC. There is work underway through Health Information Services to ensure the accuracy, validity and comprehensiveness of information to increase the organisation's confidence in data quality. This applies to validation of hospital acquired complications (HACs) data.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Comments
JFPH complies with the HSP Risk Management Framework and related policies. It has an integrated risk register, from which risks are reviewed at a frequency according to the level of residual risk or incident occurrence. KPIs in place for serious risks to make sure monitoring of such risks is regular and effective. HSP has two layers of Risk Register- Corporate and Hospital risk registers -The Hospital risk registers are co-ordinated nationally so any new risks arising from sentinel events or other issues are added to all risk registers nationally. Risk management policies and the Risk Management Framework are regularly reviewed to ensure they reflect best practice and they are adjusted to maintain the effectiveness of the risk management system. There are also policies that address specific risks - such as workplace health & safety, fraud prevention, infection control, bullying, and emergency procedures. These policies guide staff on risk identification, assessment, and reporting. There are a range of business continuity and emergency response policies available to the organisation. These policies set out staff responsibilities if their work area is impacted by internal or external issues. Examination of the hospital risk register by assessors confirms that the organisation identifies and manages its risks well, taking action to mitigate them wherever possible. Several examples were provided by both clinical and non-clinical personnel, suggesting an organisation-wide approach.

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Staff learn about risk at orientation supplemented by ongoing education. Managers receive specific education in this regard. A 'train the trainer' model is in place supported by the National Clinical Risk Systems Manager. The workforce is notified of risks (and their management) through many communication streams. This includes via HINT intranet access, organisation-wide emails, ward meetings, through attendance at committee meetings and through National Webex teams. An example of the management of a serious risk was provided when JFPH played a key role managing the COVID-19 pandemic through unexpectedly caring for several Covid positive residential aged care patients displaced through a serious outbreak at their facility. The situation which had risks on multiple levels, was very well managed with little transmission to Covid negative patients or to staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
HSP dictates its hospitals' approach to incident management and open disclosure through a range of related policies. RiskMan is the incident management system which allows all staff to report an incident, from where it is analysed, trended and reported. At JFPH there is an increasingly strong reporting culture as the number of lodged incidents (particularly lower level) have grown in recent years. Assessors found that the workforce is well-supported to recognise and report incidents via a range of mechanisms, including orientation, ongoing training and assistance from the Quality Manager. The Quality Manager reviews all incidents at hospital level and reports trends through KPIs to HSP. Serious incidents such as sentinel events are elevated via the HSP hierarchy to the Board sub-committee, the Clinical Care Committee. All incidents are reviewed and adhere to the requirements of the HSP high level incident policy. Consideration is given through the review process to adding risks identified via incidents to the risk register. Examples of this were provided.

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Recommendations arising from incident reviews are captured and monitored either by relevant committees (e.g. Infection Control or Medication Safety) or action plans are oversighted by the hospital Clinical Governance Committee. Clinical staff are kept up to date with progress of reviews and any outcomes, which may necessitate a hospital-wide education program, or a local response. The analysis and recommendations arising from incident management have been used to improve systems and processes. Several examples were provided to support this statement. Reporting areas of concern by patients, carers and families is encouraged and JFPH provides information for patients, carers and families with Rights and Responsibilities posters and brochures displayed throughout the hospital plus there is a HSP website online contact page with any relevant to JFPH would be sent to the JFPH General Manager (GM) for review. Staff are able to provide feedback about the incident management process and in turn receive feedback about RCA outcomes and incident trends at ward/departmental meetings. VMO's receive information through the MAC minutes, craft group meetings and general emails. Each clinical area has a Safety and Quality board to display data related to their rate of incidents. Several amendments have been made over time to RiskMan to improve its effectiveness. Several changes, and the reasons behind them were explained to assessors as evidence of improvements made.

Rating	Applicable HSF IDs
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
The HSP Open Disclosure process is consistent with the Australian Open Disclosure Framework and requirements are clearly defined in Healthscope policy. JFPH complies with the HSP policy and reports on its outcomes regarding staff training. Open disclosure is recorded when it is undertaken as a result of serious incidents. There is mandated training in the general principles of open disclosure for clinical staff and more advanced education for senior staff and VMO who may be called upon to provide formal open disclosure as part of the incident analysis process. Several initiatives have been undertaken to improve the effectiveness of the open disclosure process and include changes to the training/education process, amendments to RiskMan to better capture how/when open disclosure occurred and through the HSP Shared Learnings program.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
Comments
JFPH actively promotes the provision of feedback from patients, carers and families. Feedback is sought via electronic survey using questions based on the new Australian Patient Experience Question Set developed by the ACSQHC although all avenues of feedback encouraged, whether verbally or in writing directly to the JFPH GM. The most common means of feedback is now via electronic means. The HSP Board promotes the 'Back to Bedside project', a quality improvement initiative which promotes early and regular feedback at the bedside, increasing opportunities to address issues before they become more serious, avoiding escalation through perceived inaction. All nursing staff were aware of, and participate in, this initiative and were able to see its value. They were able to provide several examples of small but effective actions taken as a result of the process to assessors. Managers and executives also conduct 'rounds' to gather feedback and similarly act immediately to better manage patient perceptions of their care using the project's toolkit.

ACTION 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
All feedback and complaints are formally reviewed through RiskMan, trended and actioned in a timely manner. Trends in complaints are used to improve safety and quality systems and the organisation was able to provide evidence of where this has occurred. Patient feedback however is in the main very positive, consistently rating care provision as good or very good 95% of the time. JFPH staff are also offered opportunities to provide feedback regarding safety and quality systems through the regular HSP Employee Experience survey, debriefing following serious incidents, and the use of reflection tools following incidents. VMOs are also surveyed to ascertain their views. Action is taken based on results, with many examples provided to assessors.

Rating	Applicable HSF IDs
Met	All

ACTION 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system
Comments
JFPH is supported in regard to complaints management via Healthscope Feedback and Complaints Management policies, and their related procedures. Consumers are encouraged to provide feedback to JFPH, including the making of a complaint if systems outlined in 1.13 to address feedback, are insufficient. Managers at JFPH daily monitor the Qualtrics webpage as a common source of complaints; those coming through the HSP ‘Contact Us’ website are also forwarded to the JFPH General Manager for response and action.

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Patients may also complain to nurses and Nurse Unit Managers which are managed under the 'Back to Bedside' process, while the Managers' rounding process may also elicit issues about which a patient may wish to complain. Complaints through other sources such as letters and phone calls are also received although are less common now that electronic methods are ubiquitous. All formal complaints received are entered into the feedback section in RiskMan, monitored to document and track the organisational response to patient complaints. JFPH's complaint response times are reported vis Quality KPIs to the governing body (which may also be provided with detail about complaints of a serious nature). Current compliance with timeliness of response is at 100%. Feedback on complaints management is fed back to patients and staff through display on Safety and Quality Boards throughout the hospital, to the MAC and to the wider public through the MyHealthscope website. Ward staff now have access to the Qualtrics dashboard for the purpose of early response to issues. Complaints are also discussed in detail at ward/departmental meetings where the requirements of the Back to Bedside program are reinforced. Consumers are further involved through their representation on the JFPH Clinical Governance Committee. The complaint management system is regularly reviewed and has improved over time through amendments to the RiskMan platform to better capture complaint data and through display of complaint outcomes for patients and staff to note. Managers have access to a range of corporate supports for advice and direction as required to effectively address serious or complex complaints, including the National Clinical Risk Manager to ensure risks arising from complaints are appropriately managed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
The HSP policy: Diversity and Inclusion governs the JFPH approach to diversity and its management of its local high-risk population. The hospital uses demographic data from the City of Moreland LGA to inform its position and follows policy regarding asking all patients whether they identify as of Aboriginal or Torres Strait Islander descent so that supports can be tailored if required. Information regarding interpreter needs is sought on pre-admission or admission as the local area has long been a multicultural one; with patients currently identifying language spoken as English predominantly followed by Italian and Greek, then Arabic and Japanese. Multilingual information is readily available. Information gained through ongoing analysis converts to changes and updates to service provision through the strategic planning process, and is operationalised through, for example, the provision of numerous aids to reduce pressure injuries, falls, malnutrition and better manage cognitive impairment for the frail and elderly who attend JFPH for treatment. Comprehensive assessments are guided not only by HSP overarching policy but local protocols as well, with many relating to conditions associated with aging such as stroke, end of life and caring for the elderly in the Emergency Department. Pre-admission screening also captures patients likely to be at higher risk of harm, from where they may be referred to the Pre-admission Clinic for individualised care planning. Alerts arising from these processes are added to the Alert Sheet in the Medical Record, and to WebPAS for online alert.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Comments	
Although HSP is considering the introduction of an electronic record, like all HSP hospitals JFPH remains a paper based medical records system that includes both HSP and locally developed forms in accordance with HSP policy. WebPAS is integrated into the paper-based systems with forms printed out as required to the medical record. Records are oversighted by the JFPH Health Information Manager and her team with support from state and national HIMs to ensure conformity with legislative and standards requirements. All current medical records are available at the point of care; records stored in secondary storage are on site and can be readily accessed if required. A system is in place to retrieve records from off-site storage in a timely manner, which can be as short as a few hours if the need arises. Staff undergo regular education in the maintenance of accurate, complete and legible records in compliance with HSP Medical Records and related policies. In response to issues relating to the quality of documentation in recent years JFPH has a fulltime Specialist Documentation Consultant who works with clinical staff to maintain standards. Her work is obvious in that clinical documentation has improved markedly over time. While assessors observed that documentation standards are generally high and compliant with policy there is still room for improvement, incorporated into the SDC's plan. Assessors in particular noted that medical documentation remains difficult to read in some circumstances and were very pleased to hear that the MAC is actively engaged in improving the legibility of VMO handwriting. HSP has policies which guide staff to protect patient clinical records confidentiality, IT security, privacy and confidentiality, and policies relating to the release of confidential patient information. HSP has comprehensive, formal processes for development, review and document control of forms, documents and files that make up the paper healthcare record. Audits of the health record are tabled and discussed at the Clinical Governance Committee. Assessors noted that all medical records complied with the various policy/jurisdictional requirements, forms were filed in a neat and orderly manner in a standardised format and stored in such a manner that few if any records are permanently lost. This greatly assists in systemic audit of clinical information.	
Suggestion(s) for Improvement	
Given the ongoing focus on accurate clinical documentation JFPH could consider introduction of a retrospective audit process where nursing staff peer audit their documentation at local level so that staff can take responsibility for their own actions rather than simply seeing audit results conducted by the SDC or HIM which may appear unrelated to their own circumstances.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
JFPH meets the requirements of Advisory AS 18/11 as it relates to Actions 1.17 and 1.18. In this regard JFHP is subject to the HSP approach to this Advisory. A gap analysis has been undertaken across all sites. Further actions in implementing actions arising from the gap analysis are required by December 2022 and HSP is currently working towards implementing systems that can assist further data entry into the My Health Record (MyHR). JFPH complies with the HSP Policy 2.66 My Health Record with all HSP hospitals participating in the MyHR. JFPH uses standard national terminology. Data relating to nursing discharge summaries is currently regularly uploaded. Further data will be uploaded when HSP introduces an EMR, although JFPH has no timeline in regard to when this may occur.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
HSP Policy 2.66 My Health Record describes the authorised access to the MyHR and provides guidance for all HSP/BPH employees, contractors and consultants about access to and use of the My Health Record (MyHR) system. A system is in place at HSP to manage this complex process. The designated person at JFPH is the General Manager (GM). An Action Plan in place for the implementation of the MyHR system by December 2022. Advisory 18/11 has been met as per Action 1.17.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
HSP has numerous policies which reference safety and quality for all members of the Healthscope team, including the Board and Clinical Quality Committee specifying education and training in this regard from orientation and onboarding through to ongoing education for all clinical staff with which JFPH must comply. Position descriptions for JFPH managers and staff outline quality and safety responsibilities with KPIs reported to the HSP Corporate office quarterly - with action plans in place for those not reaching KPI benchmarks. The mandatory training program was reviewed in 2018 resulting in the rationalisation of the volume of mandatory training requirements. The responsibilities of VMOs related to safety and quality is via the HSP By-Laws. These are recorded in the C-Gov eCredentialling system. The By-Laws are scheduled for review in 2022 to enhance current requirements. JFPH facilitates clinical placements for Enrolled and Registered nursing students with many learning opportunities in place with the collection of feed-back an important component of their placement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
Comments
A team of clinical educators at JFPH manage all aspects of the hospital's training needs. Included are mandatory training, orientation sessions for new staff, development of an education calendar and maintenance of ELMO, the online training platform for HSP staff. Much of the mandatory training is now online with all staff having access. The mandatory training program was recently reviewed, rationalised and streamlined. Support is in place for members of the workforce who may have difficulties with the English language, or who are not computer literate. Competency assessment is on site, although this has been compromised throughout the COVID-19 pandemic due to imposed limitations on non-essential staff attending the hospital.

ACTION 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
HSP identify any training items required on the Shared Learning Report with these actioned by relevant hospitals. Quality and safety outcomes which do not meet benchmark become a focus for targeted education, with improvements monitored through the quality improvement process at the Clinical Governance Committee. JFPH regularly review their mandatory training calendar which has been adapted to now include ATSI Cultural Awareness training. Compliance monitoring is undertaken, and mandatory training compliance is quite high, although action plans are in place to reach targets affected by the Covid pandemic. Assessors found that nursing staff value their educational opportunities and there is high attendance at non-mandatory education. Responsibility for VMO education and training is governed through the HSP bylaws, and maintained in C-gov, the e-credentialling database. Agencies are contracted to ensure their staff have ongoing competency in BLS, Fire preparedness, manual handling and infection control, monitored through KPIs. Departmental orientation is also a requirement for agency and locum personnel.

Rating	Applicable HSF IDs
Met	All

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
JFPH supports its staff to improve their cultural awareness and cultural competency in order to better meet the needs of Aboriginal and Torres Strait Islander patients. Mandated training in this regard commenced in 2019. To assist in its strategy to enhance cultural awareness, JFPH supports displays of HSP commissioned ATSI artwork, the display of the HSP Reconciliation Action Plan throughout the hospital and an acknowledgement to Country is part of all JFPH meetings. Key events such as NAIDOC Week and National Reconciliation Week are promoted. The requirements of Advisory AS18/04 have been met.

ACTION 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Comments	
Performance review and development processes for JFPH staff are structured and well established. In accordance with HSP policy, performance review of all JFPH staff at conducted at three months post-employment and annually thereafter. Appraisal tools are inclusive of performance priorities (governance pillars), professional goals, educational training and development needs and monitoring of compliance with mandatory training. Identified training requirements are then incorporated into JFPH's training program. Interim appraisals are also conducted on the occasion of unsatisfactory performance and BPH has access to the HSP Human Resources Department for performance issues if required. At assessment assessors found that all staff in the organisation they spoke with had undergone a performance review in the preceding 12 months.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Comments	
JFPH has well established processes that support the credentialling and defining the scope of practice of its VMOs, nursing and allied health staff. HSP has a suite of policies relating to credentialing and scope of practice with which JFPH must comply in order to demonstrate effective governance over defining the scope of practice of clinicians. This is closely monitored through the KPI performance monitoring process. VMO credentialling and scope of practice is captured in the online cGov system. Information on credentialing and scope of practice is available to relevant JFPH clinical staff (for example staff in the Operating Suite) within WebPAS. JFPH interrogates the AHPRA registration checking system weekly to ensure VMO registration, and any imposed restrictions on practice, remain current. The position descriptions of staff denote scope of practice and are subject to review according to a review schedule. No nursing staff operate within an extended scope of practice at JFPH. The incident management system provides feedback on both VMO and staff performance with JFPH forums for clinical peer review being: Medical Advisory Committee, craft group meetings and the Clinical Governance Committee Clear processes are in place, through HSP policy, to guide the introduction of new clinical procedures and clinical technologies. A range of matters must be considered in any applications for new technology, including credentialling, scope of practice and training requirements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	
HSP has an online e-Credentialing Application and Management System which is fully implemented at JFPH. This is monitored by the JFPH credentialing officer. The JFPH credentialing audit compliance is sustained at 100%. Although credentialling processes are thorough and well developed, all aspects are kept under review by HSP in recognition of this important element of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Comments
JFPH has processes in place to ensure that its staff understand and perform their roles in safety and quality and assigns roles to them via their position descriptions. It was obvious to assessors that clinical staff understand their responsibilities in this regard, particularly in relation to accurate and comprehensive assessment and care planning. They take their role in minimising risks to patients very seriously and understand both the importance of incident reporting and the need to implement quality improvement activities arising from incidents and near misses. The role of clinicians in the provision of safe and high-quality care is emphasised during orientation and is further reinforced during mandatory training, particularly related to designated very high-risk areas. All training and education emphasise safety and quality. The monitoring of system effectiveness through the audit process is increasingly understood. Agency/locum workforce requirements are clearly articulated, including an assurance that each person has the appropriate skills to provide safe patient care including an understanding of quality and safety systems in use at JFPH, achieved through contracted arrangements with the various agencies supplying clinical staff. In accordance with HSP requirements, JFPH's Safety and quality Plan is aligned to the HSP Safety and quality Plan and outlines the priorities for the year. Staff have access via the public access drive.

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Assessors noted that Quality Boards display safety and quality information throughout the facility. The Boards include information related to quality improvement activities, audits, training data, education programs and the NSQHS quality standards. This reflects the focus that front line clinicians have on monitoring and improving the care they provide.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
JFPH has systems in place which ensure clinicians can safely fulfil their designated roles, including out of hours. A chain of command policy is in place for the escalation of concerns with the JFPH Director of Nursing (or her delegate) on call 24/7 to ensure that a member of the Executive team is always available to provide support and leadership should a significant issue arise. Enterprise agreements set out supervisory requirements with departmental Managers accountable to ensure staff receive their required training. There is a register of employed staff and their relevant qualifications. JFPH has well developed formal supervision arrangements in place for Division 1 and 2 student nurses. Systems are in place in the Complex Care Centre (CCC) for overseeing the CMO workforce with support from an intensivist available at all times. Similarly, there is always access to a FACEM in the Emergency Department. Given that care is provided by VMOs providing care in relative isolation (or in leading a multidisciplinary team) nursing staff were able to articulate how they would escalate care in the event that they believed a clinician was impaired or having difficulty during a surgical procedure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
At JFPH clinicians have access to a wide array of policies, protocols, guidelines, clinical pathways and decision making tools on the intranet (HINT) or via the HSP librarian. Clinical pathways with variance analysis are available on HINT and clinical clusters/teams discuss relevant pathways and guidelines. Clinical guidelines are distributed to the JFPH MAC for discussion and quick access. Guides for key guidelines are available via the HICMR website (infection control). Assessors noted that JFPH has reviewed the Australian Commission on Safety and Quality in Health Clinical Care Standards and has or is in the process of implementing several CCS relevant to its casemix. Nationally standardised care pathways are in use in the Emergency Department e.g. STEMI, Asthma and Stroke and has most recently introduced a Sepsis pathway and a standardised process to manage anaphylaxis.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
Comments
JFPH is increasingly developing systems to monitor variation in practice against outcomes and providing feedback to clinicians. Benchmarking against external measures occurs where there are known sources, e.g. ANZIC database for ICU outcomes and a range of cancer databases. The hospital submits data for review to ACHS, reporting hospital wide Clinical Indicator information. Other mechanisms include speciality submissions, additions to registries, Hand Hygiene Australia submissions; Hospital Acquired Complications (HAC) and the Qualtrics web platform to monitor consumer feedback are in place.

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Org Code : 220189

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
The quality statements described in the Australian Commission on Safety and Quality in Health Care (ACSQHC) Colonoscopy Clinical Care Standard have been incorporated into the management of the JFPH colonoscopy service, and antimicrobial stewardship variation is actively managed by the Cluster AMS Committee in line with requirements of the relevant Advisory from the Commission. Assessors were able to confirm that colonoscopists credentialled by JFPH are registered with the Gastroenterological Society of Australia (GESA) and collate and present relevant key performance indicator (KPI) data as part of their recredentialling. This is in accordance with requirements described in the ACSQHC Fact Sheet “Certification and Recertification of practising adult colonoscopists”. Assessors agree that the requirements of ACSQHC Advisory AS18/12 “Implementing the Colonoscopy Clinical Care Standard”, which relates to actions 1.23, 1.24, 1.27b 1.28a and b, are met. As a private hospital, JFPH has a range of mechanisms to monitor variations in practice which may lead to unexpected outcomes and provide feedback to clinicians via the MAC and craft group meetings. JFPH records its risks associated with poor outcomes of care in its risk register and mitigates accordingly.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
JFPH maximises safety and quality of care through monitoring its environment and maintaining its infrastructure at a high standard accordance with related HSP policies. The hospital presented in a very neat and tidy condition despite its age. Infrastructure is well maintained as evidenced by maintenance logs and other documentation. Contractors are well managed to ensure safe, quality provision of service within a compliance framework.

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
The hospital is a juxtaposition of the old and new, with the recent addition of a new Emergency Department, a Critical Care Centre, Operating Suite and wards. Carparking is now close by for both patients and staff adding to safety. All health service facilities are located on the one plot of land, including day oncology/procedures unit: imaging, pathology and consulting suites. The new Day Surgery Unit is accessed from the entry foyer making it convenient for patients and their carers. The extensive changes to clinical infrastructure have been a long time in the planning and preparation, taking into account the needs of consumers for safety and comfort, and for clinicians in regard to the provision of a functional care space through contemporary design features. Patient rooms are mostly single or double rooms with four bed wards placed close to nurses' stations for patients requiring close observation. Rooms are peaceful, well-appointed and welcoming. Preventative maintenance and facility management, together with biomedical equipment servicing are contracted to third parties and relationships appear to be effective. Reporting is robust. The JFPH Disaster Plan is in place and well monitored, with all staff aware of their responsibilities in this regard. The hospital has an asset register monitored by the Finance Manager.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Comments
Assessors reviewed incidents at JFPH which indicated that the hospital is a low risk in regard to patients presenting with unpredictable behaviours. Notwithstanding, processes are in place to manage this occurrence. Higher risk areas have been identified through occupational violence and aggression audit and patient violence and aggression is a standing risk on the risk register. Staff are well educated in regard to emergency management in relation to Code Grey and a Code Black. WAVE 1 & 2 Workplace aggression and Violence training is mandated for all staff. WAVE training includes de-escalation methods to reduce the risk of violence. Strategies in place include on site security (who will escort to their cars after dark if required); night-time lockdown and the strategic placement of duress alarm buttons.

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Specific protocols are in place regarding management of high-risk patients, with specific alert processes on the medical record for patients known to be unpredictable. Care plans may be in place, developed in collaboration with the patient's family to identify triggers and calming measures which may be of use when providing care. Policies and documentation are in place to guide transfer arrangements should the need arise for patients to be moved to more suitable facilities. Single rooms are available should a calm and quiet environment be beneficial to patient care. Education and training in the recognition and management of patients with delirium or cognitive impairment have assisted in improving outcomes for these patients, enabling clinical staff to monitor and respond effectively to agitation and/or delirium and/or behaviours of concern and to guide management of a patient's behaviour. In the event of an incident, employees are well supported through the HSP Employee Assistance Program.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
Signage at JFPH is clearly visible, illuminated external to the building. Signs are kept clean and gardens are kept trimmed to maximise visibility. Due to its numerous iterations over its long life and its land-locked site, the hospital has extended awkwardly over the years and could be difficult to navigate for some patients. However internal signage is plentiful and way finding was easy for assessors. Currently entrances are controlled at key points for COVID-19 purposes. Staff performing the check in process were helpful in guiding patients through the entry process and in directing them to where they needed to go, as visitors are currently still significantly restricted. Ambulance bay parking is identified and designated and lined walking areas into the consulting suites are marked for the safety of pedestrians. The staff car park is adjacent to the hospital and can be accessed internally. It is well lit by controlled switches so that residents nearby are not exposed to constant bright lights. Fire safety maps and evacuation signage assist in egress from the buildings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
JFPH complies with HSP Policy 2.06 Visitors and HSP policy 0.01 Code of Conduct in regard to visiting hours. In response to frequent changing of visitor restrictions due to COVID, the hospital has continued to inform the public whenever a change has occurred and reviews requests on an individual basis. Flexible visiting arrangements are identified on the website. Conversations with staff indicate that a flexible and compassionate response to visitor requests is currently in place. This was exemplified in regard to the very frail aged care residents who were unexpectedly transferred to JFPH following a large outbreak of COVID-19 at their facility. Several patients died as a result of their frailty and infectious status. Families were much appreciative of efforts taken to provide them with contact with their loved ones.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
JFPH acknowledges the traditional owners of the land on which the hospital is built, conducting formal acknowledgement at the start of meetings and formal occasions. Staff are appropriately trained in cultural competence and provide a welcoming environment to all patients. The Aboriginal Liaison Officer works has established contacts within the City of Moreland and their Aboriginal Liaison Staff and with local aboriginal cooperatives. Thoughtful, local Aboriginal artwork is on display throughout the facility. The Aboriginal and Torres Strait Islander flags are displayed at the reception desks of the hospital and the consulting suites. For several years JFPH has acknowledged both NAIDOC and National Reconciliation Week with a range of culturally sensitive activities.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

ACTION 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
Interviews with staff and patients together with a review of policies and procedures supporting partnering with consumers show that the principles of safety and quality are applied when these documents are developed. Consumers are engaged in policy development, implementation and training, and there is an annual consumer consultant planning day. They assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation. The 'Back to Bedside' strategy focuses on patient stories and includes training which is provided to both clinical and non-clinical staff on patient-centred care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers
Comments
A review of documentation and interviews with staff and consumers confirmed that the organisation aims to improve partnerships with consumers at all levels. The Assessors observed how these strategies are monitored and how the organisation reports on partnering with consumers. ‘Back to Bedside’ has resulted in improvements to patient experience including quality of treatment and care. A number of elderly patients with COVID-19 were admitted to the hospital and iPads were used to support virtual visits for families and carers. This was particularly helpful for patients without smartphones. A hospital orderly checklist booklet, which supports patient tracking and transfer was developed by the support services team. Information is checked in front of the patient and the booklet stays with the patient.

ACTION 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Consumers are able to provide comments on the JFPH website, and are invited to complete a survey after discharge, where there was a 34% response rate in 2021. These reports are sent to the appropriate committee for action. Consumer consultants were very enthusiastic about their roles, and each one is allocated to a different range of areas. The consultants provided examples of feedback they have been able give from the patients; and they also appreciate being able to have input into hospital committees, as well as commenting on patient information before it is published. The Quality Manager manages the consumer consultants, who felt well supported in their roles.	
Suggestion(s) for Improvement	
Consideration be given to providing multi-lingual feedback forms.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Comments	
A review of the health service demonstrated that the Charter of Rights (consistent with the Australian Charter of Healthcare Rights) is readily available throughout, and that action is taken to ensure that it can easily accessed and understood.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	
Interviews with staff indicated that they understood their responsibilities with respect to informed consent. The consent policy and processes comply with legislation, and reference best practice. Compliance with procedure informed consent is audited and compliance is reported as 99% in June 2021. The requirements of Advisory 18/10 have been met with respect to informed financial consent, and at 1/6/21, patients had signed 100% of the financial informed consent forms.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.5	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care, plus the process to be followed if a substitute decision-maker is required. Staff were able to articulate this process and access the relevant policy. The discharge planners receive referrals and are able to sit with the patient and assist in this process. Advance care planning, cognitive assessment by the occupational therapist, and physician discussion re decision making are all processes which can be offered. If a substitute decision maker is required, WebPAS and the patient medical history have the appropriate documentation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
Interviews with patients and clinicians confirmed that staff work with patients, or a substitute decision-maker, in shared decision making about their care planning and goals of care. Information is documented in the comprehensive care plan, and information was seen by assessors on some of the patient care boards in their rooms.	
Suggestion(s) for Improvement	
That there be an increase in the information documented on the patient care boards.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Comments	
Staff and patients were able to describe to the Assessors how patients are actively involved in their care. Patients and carers interviewed confirmed this, and satisfaction surveys undertaken by the organisation also support that patients are satisfied with the level of engagement in their care which has consistently been reported above 90%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
A review of information provided to consumers through a wide range of mechanisms demonstrated that significant action has been undertaken to align communications with the needs of the patients, carers and their families. The diversity of the local community has informed communication and information that is available that reflects this diversity. Patient satisfaction with communication and information provided to them is included in satisfaction surveys and reported positively. This was also corroborated by patient interviews. A brochure 'Asking the Question' for Aboriginal and Torres Strait Islanders provides information and contact details of local support services. A Disability Action and Plan has been developed and one of the consumer consultants is a disability advocate. A diversity profile has been established and is reviewed yearly.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
Documentation reviewed by the Assessment Team, and interviews with consumer representatives confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Comments	
Clinicians were able to articulate how they effectively partner with patients in their care whilst accessing services provided by the organisation, and how they work with patients to support their ongoing care needs, such as providing discharge information sheets for specific procedures. Patient satisfaction with the information provided to them is reported as high, and a number of the publications have been reviewed by consumers. Patients receive a nursing discharge summary which is discussed on discharge; and the pharmacist, where applicable provides a medication profile and provides appropriate medication counselling. Patients reported being satisfied with discharge planning. Patients who were interviewed by Assessors also supported that they felt information was provided to them in a manner and format they could understand.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Comments	
Interviews with members of the Consumer Consultants group confirmed their active role in the governance and evaluation of health care across this organisation. This is supported by the role consumers play on a range of key committees and groups. In seeking feedback on service delivery, the organisation engages various mechanisms that encourage input from a diverse range of consumers and from the broader community, and this is reflected in the consumer consultants and volunteer patient companions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	
Documentation and interviews with consumer representatives confirmed that they felt supported in their roles. This includes orientation for consumer representatives and ongoing education where needed. Consumer representatives reported being satisfied with the level of support provided to them, and also stated that the organisation was responsive to their information needs in interpreting data / reports / documents. Consumers were involved in the JFPH facility upgrades, and they also audit patient experience.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
The organisation has pursued a range of activities to better partner with local Aboriginal and Torres Strait Islander communities, and to better understand and meet their specific and unique healthcare needs. Staff interviews and a review of documents confirmed that organisation actively engages with members of the local Aboriginal and Torres Strait Islander communities and seeks their input into service planning and care. There is a JFPH liaison officer, and a mentor provides support on an 'as necessary' basis. JFPH has formed partnerships with groups such as Merri Health, have a subscription to Koori Mail, have an aboriginal health related section in the monthly newsletter and have access to patient information brochures designed specifically for the Aboriginal and Torres Strait Islander population.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
Consumer representative and managers were able to explain how the organisation works with consumers to incorporate their views and experiences into training and education for the workforce. Staff interviewed were also able to provide examples of this training. Training records and programs were sighted by the assessment team that support this occurring. There is consumer involvement in strategic planning days.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

ACTION 3.1
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship
Comments
John Fawkner Private Hospital (JFPH) has a very active and effective infection prevention and management framework provided in collaboration with and governed by its parent corporation Healthscope (HSP) and the organisation's expert external providers of infection control (IC) services (HICMR). Both HSP and HICMR ensure that there is a very comprehensive suite of evidence-based policies to guide practice. These policies are regularly updated and comprehensively monitored through numerous audit and surveillance processes. The governing body takes considerable interest in infection control and is kept informed of infection prevention and control (IPC) outcomes across all its hospitals via a dashboard to which JFPH contributes data for benchmarking against other sites in its peer group. JFPH's performance is very good in all elements, with almost no hospital acquired infections identified through its surveillance program and high levels of staff compliance with policies monitored through the audit schedule and reported to the IPCC. JFPH is part of an effective Healthscope Webex IC team which monitors all infection control activities across the group, including infection rates across all of the corporation. This IC cluster reviews related incidents, ACHS clinical indicators and guides the implementation of policies and procedures at each site via local Infection Prevention and Control Committees (IPCC). Risk management in infection control is particularly robust at JFPH, compliant as it is with the Healthscope Risk Management framework and its governing policies. All infection control related risks on the hospital's risk register are regularly reviewed and have individual management plans to reduce/manage associated risks. Management plans are well monitored and assessors noted effective controls, supported by nil/negligible rates of infection. There is sound governance over the anti-microbial stewardship program and the Medical Advisory Committee (MAC) takes great interest in and monitors local practices in this regard to mitigate related risks. HICMR conducts annual risk assessments of JFPH's system and facilities from which resulting recommendations are formally addressed. Progress on meeting recommendations is reported to the hospital executive and via the Healthscope hierarchy to the Board. To ensure the risk of infection is reduced to a minimum mandatory training regarding effective prevention and management of infections is in place. This program is very comprehensive and compliance with completion of both the eLearning modules and any accompanying competencies is very high, with some elements more than 90%.

ACTION 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Additional discretionary modules are available and all staff have access to HINT, which provides Healthscope Library materials for effective infection control including Australian Guidelines, the Australian Hand Hygiene Initiative; HICMR Policy and Procedure Manual, and audit tools. This broad approach ensures robust, evidence-based information and support is available to staff at all times. The IPCC in collaboration with HICMR is responsible for the management of JFPH's COVID-19 response which has been a massive process associated with very positive outcomes. JFPH has also met the requirements of the National Standard Preventing and Controlling Infections 2021 as set out in Advisory AS 21/01 through implementation of its action plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program
Comments
JFPH applies quality improvement systems to monitor the performance of its infection prevention and management program. A comprehensive audit program across a wide range of infection control parameters is in place, including extensive surveillance directly related to its casemix. Audit outcomes confirm a high level of attention to infection control across the organisation. Infection surveillance data is reported both internally to HSP and to VICNISS for benchmarking against peer hospitals. Additional data is provided to Hand Hygiene Australia. An Infection Control Plan is in place at JFPH. The plan is annually reviewed and is multifocal, including staff health, the surveillance framework and a risk management plan.

ACTION 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Incidents relating to infection control are entered into the organisation's RiskMan database from where they are analysed. Review of the IMS indicates that such incidents are negligible as infection rates are often zero. Should there be an infection however, an action plan would be developed as warranted from incidents or performance indicators which do not meet the required mark and would be closely monitored until identified improvements are noted. The effectiveness of the antimicrobial stewardship (AMS) program is monitored by an AMS committee and significant improvements have been identified in recent years as noted through surveillance data provided by the private pharmacy service and audits conducted by the IPC team. Results of all audits and quality improvement activities are provided to the Medical Advisory Committee (MAC) for review. Numerous examples of strategies introduced to improve infection prevention and control and antimicrobial stewardship were provided to assessors, most with demonstrated positive outcomes. Many related to COVID-19 while evidence-based management of sepsis has also been a prominent activity in the Emergency Department and the Complex Care Centre (CCC). The outcomes of all activities related to the prevention and control of healthcare associated infections, and the AMS program's activities as articulated in the IPC Plan are monitored by JFPH's Clinical Governance Committee, and by HSP. Outcomes are also displayed for staff, patients and visitors on Quality Boards in each ward/department. Related issues are discussed at regular ward/departmental meetings, and at the MAC. Results are also exhibited on the My Healthscope website – John Fawkner Private Hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation was able to provide a significant amount of evidence demonstrating where and how clinicians actively partner with patients to involve them in their own care; meet their information needs and share decision making in regard to infection prevention and control. Assessors attended clinical handovers where interaction took place at the bedside and clinicians spoke of their role in educating their patients. Conversations of this nature are documented in the patient record. Patients were able to confirm such interactions were helpful and appropriate, assisting them to make their own decisions regarding their care. Individualised education is provided to patients being nursed in isolation. Numerous examples were provided of brochures available for patient information in regard to infection prevention and control. Some brochures outline general infection control principles. Others are specific to an identified risk and clinical staff explain the brochure's content to the patient, obtaining feedback that the information is understood. An annual audit is undertaken to identify gaps in patient knowledge in regard to transmission-based precautions, leading to ongoing improvement in education.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.4
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
In Victorian hospitals surveillance of healthcare associated infections (HAI) is mandated through the Victorian Healthcare Associated Infection Surveillance System, known as VICNISS. Accordingly, JFPH contributes data through its audit program. The surveillance program at JFPH extends beyond that required by VICNISS, and includes hand hygiene, exposures to blood and body fluids, and staff immunisation. Antibiotic monitoring also forms part of the surveillance process and most recently specific COVID-19 initiatives have also been included in surveillance measures. In regard to antimicrobial stewardship, JFHP submits data annually to the National Antimicrobial Prescribing Survey (NAPS).

ACTION 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Surveillance is conducted via the HICMR surveillance toolkit which provides a standardised approach and facilitates benchmarking across Healthscope hospitals. Indicators collected include Staphylococcus aureus bloodstream infections, surgical site infections and influenza vaccination rates. Most recently Covid vaccination rates have been included. Assessors reviewed audit results relating to the surveillance program and noted negligible infection rates, consistently high vaccination rates and steadily improving antimicrobial prescribing, if from a low base. The Quality Manager was able to describe processes in place should an infection be identified, which included individual review in each case. Results indicate effective systems of infection control with all outcomes below current state benchmarks established by VICNISS. JFPH's surveillance data informs strategies to reduce risks associated with HAI as identified through HICMR policies. All surveillance outcomes are reported to staff, consumers and via the JFPH clinical governance structure (including initially the Infection Prevention and Control Committee) to Healthscope and its Board. Results are tabled at the MAC meeting and relevant craft groups. Assessors noted related information displayed on safety and quality boards throughout the hospital. Selected surveillance information is also presented on the MyHealthscope website, including rates of Staphylococcus Aureus bacteraemia, MRSA, MSSA and hand hygiene.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.5
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements
Comments
JFPH has processes in place to apply standard precautions and transmission-based precautions in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. HICMR policies define and describe standard and transmission-based precautions and are readily available to staff in HINT, including the availability of a Transmission-based precautions Toolkit. HICMR also provides a 24hour consultancy service should nursing staff have any questions. New infections are reviewed daily and both the HICMR consultant and the IC Consultant are available to assist staff in the application of relevant precautions as a result.

ACTION 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Assistance is also provided to environmental and food services staff. In discussions with nursing staff, each nurse could readily identify relevant policies and procedures and knew how to access expert help if required. A Transmission Based Precautions Box is available in each ward for ease of access to appropriate equipment. All patients admitted have standard precautions implemented. Patients whose pre-admission COVID-19 screening is not available are clearly identified as Suspected Covid (SCOVID) and strict isolation processes are in place until a negative result is obtained. When a transmissible infection is identified, the IPC team is available to ensure that appropriate screening, precautions and patient placement occur, usually in a single room. Signage used for transmission-based precautions (TBP) is clear and specific. Terminal cleaning requirements are clearly documented and audits indicate very high levels of compliance in this regard. An alert is entered onto the Alert Sheet at the front of the Medical Record and on WebPAS so that all staff are aware. Compliance with policy in this regard is well monitored and outcomes show effective application of appropriate precautions, including donning and doffing of protective personal equipment (PPE).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.6
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements
Comments
Clinicians assess infection risks and use risk-based transmission-based precautions as required in accordance with related HICMR policies. Assessment of infection risks is a key element at all entry points to the organisation, whether it be for elective pre-admission, non-elective admission or via the Emergency Department. Specific assessment for COVID-19 risks is included. Patients with colonisation or infection by locally or nationally significant organisms are appropriately identified and managed in accordance with policy, supported by advice from the HICMR consultant. JFPH has access to an Infectious Diseases Physician should it be required.

ACTION 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients’ risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Although standard precautions are applied in every case, decisions regarding the need for transmission-based precautions are dependent on the infectious organism and hospital’s capability. The hospital has a single negative pressure ventilation room in the ICU or the patient may be nursed in a single room (dependent on the mode of transmission). Additional factors such as environmental controls; transportation within the facility; cleaning procedures and equipment requirements are taken into consideration. Specific cleaning requirements have been defined and quality improvement activities include product changes to keep abreast of best practice. An excellent example relating to management of infection risks and the use of transmission-based precautions was provided to Assessors in regard to JFPH’s response to COVID-19 when in July 2020, with little warning, it was required to admit several patients from a residential aged care facility which had been forced to close due to a large COVID-19 outbreak amongst residents and staff. Urgent assessment and placement of infected patients was a key feature of its pandemic response and the staff are justifiably proud of the fact that there was almost no spread of COVID-19 between the nursing home patients or to staff at JFPH. Appropriate personal protective equipment (PPE) is in use and, along which the implementation of transmission-based precautions, is closely monitored. Processes observed by assessors appeared to be excellent, with high levels of compliance in the use of Personal Protective Equipment (PPE), including the appropriate use of high filtration masks and safety glasses, and in patient placement. Assessors further noted effective controls in place to minimise the risk of outbreaks, such as the Gastro outbreak toolkit and the Airborne Precaution Emergency Kit. An infectious clean, using appropriate chemicals is carried out once the patient is cleared or discharged, with regular audits indicating a robust cleaning framework is in place. Disinfection occurs in accordance with HICMR policies and manufacturers’ instructions. All results are discussed at the Infection Control Committee meeting and related performance indicators are reported to Healthscope and the Board via internal communications processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Comments	
Processes are in place for communicating a patient's infectious status whenever care is transferred. The IPC coordinator or the HICMR consultant reviews new infections on a daily basis from microbiology reports, setting in place the requirements for appropriate patient care. Elective patients complete a pre-admission screening tool which includes a section regarding their infectious status. Sometimes a doctor will inform the hospital of this. On confirmation of infectious status, an Alert is triggered on the Alert form at the front of the medical record, and in the WebPAS electronic alert system. This alert guides the response for the applications of appropriate precautions and patient placement. Signage used for these precautions is clear and specific, and assessors observed high levels of compliance in the use of Personal Protective Equipment (PPE) on occasions when precautions were in place. Infectious and terminal cleaning requirements were clearly documented and audits indicate very high levels of compliance in this regard also. The patient's infectious status is identified and communicated as part of the Safety Huddle and at each clinical handover. The communication when patients need to be transferred in or between facilities is well documented. The communication of infectious status when patients need to be transferred in or between facilities is well documented on the Transfer Form to minimise the risk of exposure. A phone call between providers may supplement this information. WebPAS generates the nursing discharge/transfer form sent with all transferring patients to another facility or community nursing organisation, and to the patient's general practitioner advising of infectious status.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Comments	
At JFPH hand hygiene (HH) is monitored as per the Hand Hygiene Australia program and audits are completed as per the audit schedule by trained auditors and in accordance with Healthscope policy which states that hand hygiene training is mandatory for all staff. Like many health services JFPH has continued HH audits during the pandemic. Audits are conducted by moment and healthcare worker designation and audit reports across the organisation indicate that it slightly exceeds national and Healthscope benchmarks, demonstrating compliance of round 85'%. Strategies are in place to maintain hand hygiene as high profile in the organisation. Extensive messaging was obvious throughout the hospital. Alcohol-based hand rub is readily available, with HH stations extensive and clearly located throughout the hospital. Assessors observed that hand hygiene is consistently performed by staff, patients and visitors. The IPC coordinator uses a range of innovative techniques to keep hand hygiene high profile and has systems in place to address observed occasions of noncompliance, although these are now uncommon. In the event that the organisation as a whole falls below benchmark, Healthscope requires the development and implementation of an action plan, monitored until results are consistently positive.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.9
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Comments
Aseptic technique is well monitored by the organisation through the Healthscope Aseptic Technique policy, which specifies AT as a mandatory requirement for clinical staff via the eLearning platform ELMO. New staff undertake the training on commencement. An initial risk-assessment and audit program based on the NSQHSS Aseptic Technique Risk Matrix identified all procedures where aseptic technique applied and a training program was developed for relevant clinical staff which includes both the online course and an annual competency assessment component. Compliance with competency assessment is usually high but has been complex this year due to extraneous staff not being allowed on site. Plans are in place to rebuild rates as soon as practicable.

ACTION 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
HICMR compliments the Healthscope policy with its own in relation to clinical practices and care bundles for management of therapeutic devices. Training modules, training records and compliance data was presented to assessors in regard to the organisation's aseptic technique program. Assessors were satisfied with the program's outcomes to date.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Comments	
Assessors noted that invasive devices are well managed and appropriately used in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare at JFPH. Supporting Healthscope and HICMR policies are comprehensive and easy to access. No incidents regarding the use of invasive devices have been identified and related infection rates are very low.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce
Comments
Environmental cleaning practices at JFPH are of a high standard in compliance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare, which have been risk assessed and incorporated into relevant HICMR policies and procedures covering environmental services; food services; maintenance; management of clinical waste and linen. Each policy conforms with jurisdictional requirements, legislation and Australian Standards as warranted. Each element is closely monitored to ensure compliance and results are reported regularly to the IPCC. Cleaning audits demonstrate that very high standards are maintained across the organisation, evidenced by assessors. Corrective action plans are developed and monitored on the rare occasions that variances occur. Cleaning schedules accommodate required frequencies and are responsive to emerging/changing environmental risks. Specialised workers clean the Operating Suite. Environmental Services staff are well trained in infection control and in the use of PPE through access to study days, equipment supplier training and through noticeboard placement of information. Support is provided for staff who have difficulties using information technology or where language other than English poses a barrier. All staff have relevant vaccinations in accordance with organisational policy. HICMR policies and the Transmissible Diseases Toolkit govern outbreak control, e.g. Gastroenteritis. All staff who provide care in the clinical setting are appropriately trained in the use of personal protective equipment, including donning and doffing. All relevant staff have been fit tested for high filtration masks although assessors noted mostly one size fits most masks in use as quality control in this regard has improved throughout the pandemic. Face shields or safety glasses were also worn in compliance with policy. Audits confirm effective infection control through this mechanism due to negligible transmission rates between patients and staff.

Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Comments	
Processes are in place to evaluate and respond to infection risks for new and existing equipment, devices and products used in the organisation; several examples were provided to assessors. The Infection Control Coordinator/HICMR consultant are active members of the Clinical Product Evaluation Committee and the system requires that they are always consulted when minor or major building works are planned. Assessors noted that the hospital including back of house, presented as extremely clean and well maintained. The kitchen was very clean and functional, with staff enthusiastic in regard to the new dishwashers. Assessors observed further plans for a kitchen upgrade. Given space constraints a single loading dock currently supports the organisation necessitating close monitoring of clean and dirty workflows, particularly relating to linen transport. Such processes were observed to be meticulous by assessors with linen management appearing to be appropriately handled, transported and stored in accordance with the relevant AS. Future plans for this area will overcome current issues, which are identified as risks by the organisation. HACCP food services audits demonstrate a safe environment for food handling. Segregation, storage and disposal of all waste meets standards and environmentally friendly systems are used whenever possible. Building maintenance and repair, including equipment, furnishings and fittings, has recently transferred to private contractors under robust systems of infection control, including maintenance schedules, a water management plan (with a Legionella management plan) and a HEPA filter test plan. All related audit outcomes are rigorously oversighted by the IPCC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.13
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients
Comments
A risk-based workforce immunisation program which is consistent with the current edition of the Australian Immunisation Handbook and with jurisdictional requirements for vaccine-preventable diseases is in place at JFPH, in accordance with the Healthscope Policy – Immunisation for Vaccine preventable diseases – Staff, and HICMR policy Staff Health. All new staff must be fully compliant with the requirements of the policy before commencement, providing serology or vaccination evidence, with data entered into the RL6 software database. Any vaccinations provided on site are added. The program provides statistical data related to immunisation at JFPH for KPI monitoring purposes. Existing staff are requested to provide updated immunisation and vaccination status to the ICC for addition to the database. This has been particularly important in regard to COVID-19 vaccination as it is a jurisdictional requirement that healthcare workers be fully vaccinated. Vaccination against seasonal influenza has been round 60% in 2021, with Covid19 at 100%. A risk-based immunisation matrix is in place with ED designated the highest risk area for droplet/airborne infection. Management is in line with the requirements of the Australian Immunisation Handbook. Blood and body fluid exposures are monitored by HICMR and managed in a sensitive manner in accordance with Staff Health policy. Vaccination status is reported to VICNISS and monitored by the IPCC.

Rating	Applicable HSF IDs
Met	All

ACTION 3.14
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure
Comments
Assessors observed that processes for reprocessing consistent with AS4187-14, in conjunction with manufacturers' guidelines were of very high standard at JFPH. Reprocessing of reusable devices occurs in the CSSD, operating under the HICMR Sterilising Services Manual which reflects relevant national and international standards.

ACTION 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
JFPH's 4187/14 Gap Analysis and Action Plan are almost complete thanks to the recent redevelopment of the Operating Suite and CSSD. Remaining works, including those in the Endoscopy Suite Cleaning Room relating to new drying cabinets are scheduled for 2022, having received Capex approval. In the meantime, associated risks have been placed on the organisation's risk register and are currently mitigated to HICMR's satisfaction until the works can take place. Assessors confirmed that this is the case. Staff are well trained and undergo annual skills assessment for a range of skills, including the tracking of endoscopes and diagnostic probes. Integrity of sterilisation is rigorously monitored and regular microbiological testing occurs in the endoscope cleaning room. Audits confirm processes follow procedure and standards, reinforced by visits from assessors who observed cleaning, disinfecting and sterilising of reusable devices and confirmed that the requirements of the policies and procedures to support the process were met. A manual tracking system called the Meditrax Traceability System is used to track all reusable medical devices (RMDs) across all sterilising systems in use at the hospital. These include porous load steam sterilisation and low temperature hydrogen peroxide 'Sterrad' systems. Meditrax can track instruments and other RMDs to individual patient should the need arise. A tracking process for flexible endoscopes and diagnostic probes is also in place using the relevant HICMR tracking form. Tracking audits are undertaken at least annually to ensure internal alignment with load logs. JFPH currently meets all requirements of Advisory AS18/07 with its plans well advanced to complete outstanding elements of its 4187/14 Action Plan in 2022.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Comments	
Healthscope Policy Antimicrobial Prescribing and Management; HICMR Policy and Procedure: Antimicrobial Stewardship (AMS) and the Healthscope Pharmacy Services (HPS) Antibiotic Stewardship governs the use of antimicrobials at JFPH, oversighted on its behalf by the AMS Committee reporting to the IPCC. Healthscope promotes evidence-based practice in line with the Australian Therapeutic Guidelines and related resources such as SA Advisory Group Guidelines on Antimicrobial Resistance (SAGGAR) via HINT to all its hospitals. by the and auditing program which comply with the current National Standards Antimicrobial Stewardship Clinical Care Standard. The AMS Committee is a multidisciplinary team comprising infection control staff, an AMS pharmacist and VMOs, including intensivists and Emergency Department doctors which oversees the AMS plan. VMOs can readily access specialist Infectious Diseases support if required. The Committee monitors the hospital's use of antibiotics in accordance with its AMS Policy, and other relevant protocols such as the Sepsis protocol and surgical prophylaxis protocols. A specific two-tiered antibiotic formulary is in place with a list of RED antibiotics requiring review by an ID physician if prescribed beyond 48 hours. A strict approval process is in place, and well monitored by the private pharmacy provider who supplies annual antibiograms and other prescribing data. The JFPH MAC actively supports and encourages implementation of the AMS policy and monitors outcomes against it, including NAPS and NAUSP data. VICNISS antibiotic prophylaxis information is available on all anaesthetic trolleys in the Operating Suite to remind clinicians of best practice surgical prophylaxis, with audits demonstrating most management meets therapeutic guidelines. Antibiotic stewardship is high profile throughout the hospital with messages for staff and patients. JFPH celebrates Antibiotic Awareness Week each year with a variety of activities promoting judicious use of antibiotics. Assessors found that the hospital is actively guided by the AMS Clinical Care Standard and that the requirements of Advisory 18/08 are met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Comments	
Assessors note that the antimicrobial stewardship program at JFPH is increasingly effective, through an enthusiastic AMS Committee and equally committed MAC. Outcomes of AMS audits are reported to the IPCC and through the clinical governance structure to the Healthscope Executive and Board. The AMS Committee reviews all antibiotics prescribed in the organisation and feeds back to individual clinicians whenever antibiotic prescribing is less than optimal. Improvements in compliance over time are noticeable in regard to surgical prophylaxis where compliance is high although the most recent NAPS report indicates that there is general compliance with guidelines and appropriateness of antimicrobial agent in approximately 50% of occasions, leaving room for improvement. Surveillance data on antimicrobial resistance is utilised to support appropriate prescribing, with the external pathology service providing relevant information. Monthly antibiograms identify rates of resistant organisms which are used to communicate local resistance patterns and assist doctors with more appropriate prescribing. This data, together with VICNISS audits are routinely reported to clinicians through the MAC, craft group and by individual email. The AMS pharmacist will also converse with individual doctors in regard to inappropriate use as an educative tool. Doctors are usually happy to be advised regarding suggested changes. Surgical prophylaxis is addressed as part of the AMS program and JFPH meets the requirements of AS18/08, Antimicrobial Stewardship, participating as it does in the National Antimicrobial Prescribing Survey (NAPS) and the National Antimicrobial Utilisation Surveillance Program (NAUSP). Compliance with indicators 6A, 9a, b and c of the AMS Clinical Care Standard has been steadily improving over time, and many strategies are in place to improve outcomes. Assessors are satisfied that the requirements of Advisory 18/08 are met.	
Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

ACTION 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
Medication management is overseen by the multi-disciplinary Medication Safety Committee and reports to the Medical Advisory Committee and Clinical Governance. The governance of medication management is defined by a comprehensive suite of policies and procedures from Healthscope and some that are locally have been locally developed. These apply a risk-based approach to effectively minimise incidents and harm. Medication management risks are identified through incidents reported in RiskMan, and appropriate actions are taken. HPS Pharmacies, the third-party provider of pharmacy services to JFPH also use an internal risk management program Paradigm and provide reports back to the hospital. Staff are provided with medication management training that is commensurate with their roles. 90% of nurses had completed the MedSafe package for quarter 2 of 2021, with the target being 92%. The training plan is to focus on mandatory training modules. Recent training sessions have been conducted on cold chain management and adverse drug reaction documentation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Comments
The organisation monitors the effectiveness of the medication management system through incident reporting and a suite of audits. Reports are provided through the governance structure to and from Clinical Governance, Medication Safety and the Medical Advisory Committees, and strategies are identified to improve performance when issues are identified. Feedback to staff includes information on noticeboards, which was observed by assessors in all clinical areas.

ACTION 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Strategies are implemented to improve medication management outcomes and associated processes. Examples include improved prescribing of discharge medications prior to the weekend, an increase in the use of the referrals to pharmacists of high-risk patients and the use of tamperproof bags for patients' own S8 and S11 medications. The legibility of documentation on medication charts, and documentation in the patient notes was identified by some staff as having the potential to cause medication errors. A discussion with some medical staff resulted in a plan for action.	
Suggestion(s) for Improvement	
That there be an audit of legibility of medication charts and patient notes, and a follow up of the results be conducted.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation aims to involve patients in their care by providing appropriate information about medications and treatments, fostering shared decision making within the constraints of the person's legal status or capacity. Consumer engagement commences at pre-admission, when patients provide medication and adverse drug reaction information, which is then followed up. The patient information booklet provides instructions about medications. Patients interviewed indicated that medication management was discussed with them, that they felt involved in the process and were able to understand the information provided.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
Scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians. In August 2021, documentation of the VMO scope of practice for surgeons and anaesthetists was 100%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
Clinicians take a best possible medication history (BPMH), which is documented in the healthcare record on presentation or as early as possible in the episode of care when it is required. In the low-risk surgical cases, assessors observed adequate history taking. For major surgery, preadmission process includes VMOs taking a medication history. During assessment assessors observed the recently strengthened process of early referral to pharmacists for Medication Management Plans (MMPs). All elective patients provide a list of medications, which is confirmed by the admitting nurse. For non-elective admissions or those admitted for elective surgery, BPMH is taken by anaesthetist in the pre-admission clinic or by the ED consultant. As the Covid threat eases and the organisation is gearing up for an increase in the number of patients, assessors suggest nurses undergo a refresher in the process of taking a BPMH, so that standards remain high when the hospital is functioning at full capacity. As new staff come on board, this should be included as part of ongoing education.	
Suggestion(s) for Improvement	
That there be further education with nursing staff to reinforce how to take a BPMH as the hospital gets busier post Covid.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	
Interviews with clinicians together with a review of documentation and observations made by the assessors confirmed that current medications are reviewed for accuracy and congruence with the best possible medication history on presentation and at transition points. Assessors noted that a lot of work has been done recently so that appropriate referral to the clinical pharmacist is completed in a timely manner. To support this, assessors note that 28 referrals were made in a 24hour period. Assessors noted improvements through the audit plan.	
Suggestion(s) for Improvement	
That there be one designated area where the medication reconciliation is signed off when completed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.7
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
Comments
The process for identifying and documenting medication allergies and adverse drug reactions is defined and monitored. Records reviewed by members of the Assessment Team confirmed their use. A new audit tool has been developed to cover all charts on which an ADR is recorded, and this is being used initially monthly to audit every patient.
Suggestion(s) for Improvement
That the Adverse Drug Reaction documentation be consistently monitored.

ACTION 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Comments	
Adverse drug reactions are reported through the incident management system and the organisation has a strong culture of reporting incidents and near misses. Medication related incidents are reviewed by the Medication Safety Committee.	
Suggestion(s) for Improvement	
That documentation of adverse drug events experienced during an episode of care be monitored routinely.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
The organisation has established processes for reporting adverse drug reactions to the TGA where required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Comments
Medication reviews in line with evidence and best practice using the Medication Management Plan (MMP) Risk Assessment form are prioritised based on the patient's clinical needs to minimise the risk of medication-related problems. Patients who are prescribed antibiotics are reviewed as part of the antimicrobial stewardship program by a pharmacist and the infection control co-ordinator. Responsible clinicians were able to describe this process of medication review, how it is documented and how action taken in response to the review are followed though. Urgent referrals were attended to, and ongoing education is being provided to staff on the WebPAS referral process to increase the rate of referral.
Suggestion(s) for Improvement
That education continue re: 1. the use of the Medication Management Risk Assessment, and 2. documentation of actions to be taken as a result of the medication reviews.

Rating	Applicable HSF IDs
Met	All

ACTION 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Comments
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Staff have access to consumer medicines information (CMI) from eMIMS, a pharmacist is available to discuss newly prescribed medications, and counselling is provided on discharge. Patients reported being able to understand information about medications that was provided to them.

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviews confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. Current medicines that a patient is receiving is reviewed at clinical handover. A medication list is provided to patients on discharge when a patient is taking high-risk medications.	
Suggestion(s) for Improvement	
Increase the use of the Medication Management Plan (MMP) to facilitate access to the information about changes to medication and the reasons for change during admission.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to information and medication management support tools via Healthscope intranet (HINT), and they reported that this information is readily accessible. Hardcopy versions of references were all observed to be up to date.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
Comments
The organisation monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage (including cold chain management), distribution and disposal of medications. All medication rooms were locked, and the S8 safes in the wards are accessible with two staff swipe cards. The ward safes were noted to be crowded, increasing the opportunity for selection error. However, a request has been submitted for those areas to have a separate S11 locked cupboard. Patients' own S8 and S11 medications are sealed in tamper resistant bags and stored in the safe in the pharmacy. Rigid hard walled containers are used for the transport of cytotoxic medications. Assessors noted the RRT emergency bag was unlocked and stored in an unlocked room. This is now in the CCU medication room, a security tag is attached and checked at each change of shift. Storage of temperature-sensitive medicines and cold chain management identified that the CCC refrigerators and the blood refrigerator are centrally monitored and checked twice daily; and recently, the Strive for 5 monitoring register was implemented for all medication refrigerators, with education being provided to staff hospital wide on refrigerator temperature checking and breech processes.

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Appropriate disposal is available for unused, unwanted and expired medications from the wards and the pharmacy. Partial doses of S8 medications not required in the ward are now disposed of in the containers with the chemical neutralising agent.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
Comments
Interviews with staff and a review of documents supported the Assessors observation that high risk medications are clearly identified. Staff were aware of APINCH, and able to identify the risks with these high-risk medications. There is an appropriate management system in place for the storage, dispensing and administration of those medications. High-risk medications on ward imprest have a 'high risk medication' sticker in front of their storage area. A review of potassium chloride ampoules has been completed, and these have been replaced with 10mmol/100mL IV bags in all areas except CCC and theatre. Assessors observed that in the S8 and S11 registers, not all the staff names were legible. There is now a signature register in each ward, and consideration is being given to ordering a name stamp for each nurse. S8 and S11 registers have been updated to include page numbers; and the register archive process has been strengthened. There were some S8 safes which were crowded; however, locked S11 cupboards have been ordered for these areas. Assessors found that IV line labelling was well done. A chemotherapy checklist is used in the wards for double checks.

ACTION 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
The VTE Prevention Clinical Care Standard gap analysis has been completed but is to be reviewed in response to assessors noting a number of prescribers signing in the incorrect place, lack of documentation for mechanical prophylaxis on some charts and some prescribers not completing the assessment information on the national standard medication chart. VTE risk alert stickers have been re-introduced, and education will be provided on the correct prescription process to appropriate groups.
Suggestion(s) for Improvement
That the gap analysis for the VTE Prevention Clinical Care Standard be repeated, including the additional areas of the correct position of the signature, documentation of the assessment and whether or not mechanical prophylaxis is required.

Rating	Applicable HSF IDs
Met	All

Standard 5 - Comprehensive Care

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

ACTION 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Comments	
Documentation demonstrates the processes that are in place for implementing the forty-seven (47) JFPH Comprehensive Care related policies and procedures, managing the many associated clinical risks and identifying the training required (four Healthscope and one JFPH eLearning packages) related to comprehensive care. Members of the large multidisciplinary team were able to describe how the organisation's safety and quality systems are used to achieve this. A review of clinical documentation confirmed that processes are in place for managing all risks associated with comprehensive care. In relation to staff education • 96% of required staff have undertaken Open Disclosure Program • 100% of required staff have undertaken the Patient falls Prevention and Management Program • 90% of required staff have completed the Managing Conflict and Challenging Behaviour Program. • 80% of required staff have completed the JFPH Pressure Injury Prevention Program	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Comments
Comprehensive care is defined and monitored with a wide range of quality improvement activities being established to improve care including • Patient incident management and shared learnings disseminated • Monthly roundtable meetings

ACTION 5.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care

- Nasal pressure injury prevention

The organisation uses feedback, data and outcomes together with evidenced-based practice to support improvements in care. The data in the form of KPIs and Clinical Indicators include:

- Hospital Acquired Complications (HAC)
- Unplanned Readmissions within 28 days
- Unplanned Returns to the Operating Room in the same admission
- Inpatients who develop >=1 pressure injuries
- Inpatient falls
- Inpatient falls resulting in fracture or closed head injury
- Patient deaths addressed with a clinical audit process
- Relief of respiratory distress in the recovery period
- Severe pain not responding to pain protocol in the recovery period
- ICU non-admission due to inadequate resources
- ICU – elective adult surgical cases deferred or cancelled due to unavailability of bed

Patient feedback includes the “Qualtrix” survey response rates to the following questions:

- Overall quality of treatment and care 86.1% (Nov21) [N=165]
- Percentage of “Very Good” and “Good” ratings 95.1% (Jan-Mar 21) [N=6455]

Rating	Applicable HSF IDs
Met	All

ACTION 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making	
Comments	
Processes are in place to partner with patients in their care and associated decision-making best suits the patient. There is a Consumer Consultant on the Comprehensive Care working party who principally oversees consumer affairs. Staff were able to describe to the Assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. Most of this is related to the “Back to the Bedside Program” which involves: • hourly patient rounding • bedside handover (involving the patient/family) • patient care board • individual patient care plans • patient/family escalation of care information	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.4
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients’ care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient’s care
Comments
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients’ care and treatment. The Medical Advisory Committee (MAC) strongly support patient-centred care and ensure that the organisation operates within their scope of service to provide care that best meets the patient’s needs. JFPH has established protocols and processes for referral where needed. Most referrals are to the multidisciplinary team (MDT), including Pharmacy, all the Allied Health Streams as well as other Medical Specialists and Nursing Champions & Educators.

ACTION 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
The clinician with overall accountability for a patient's care is defined as the admitting clinician at this organisation until such stage the responsibility for care is transferred to another clinician for example for an unexpected medical episode post-surgery (e.g., ICU) where an intensivist will be responsible during the patient stay in this department. If this occurs, new labels are printed out so that all staff know who to contact in relation to any issues related to the Comprehensive Care Plan (CCP) and the management of the patient's treatment. However, the MDT continue to work together to support the patient and the relevant family/relatives/carers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
MDT care is well established, and the role of team members is well-defined across JFPH. Staff from all professional groups and disciplines that were interviewed by the Assessors were able to confidently express how multidisciplinary care works across the hospital. The assessment team were very impressed with the interdisciplinary teamwork throughout the hospital and congratulated the collaborative teamwork and the improved patient outcomes and satisfaction this achieves. Patients, family and friends of the patient interviewed also expressed their gratitude at the holistic care model and how they felt the patient was very well cared for. They felt that they were kept informed of how the patient was travelling along with the episode of care and what to expect next, including timeframes wherever possible.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians and patients were able to describe how they work collaboratively to plan and deliver the documented comprehensive care. This was supported by clinical documentation and witnessed multi-disciplinary meetings which confirmed this. Attendance at bedside clinical handover demonstrated the patient/family/relative/carer involvement (where appropriate) in the care discussion and provision of any information requested by them. It was obvious to the Assessment team that a high standard of care and dedication to patient involvement in that care was provided by staff of JFPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	
There are dedicated processes in place to screen and assess patients for risks at the time of admission to the organisation. These are aimed at "minimising preventable harm". Clinicians were able to describe the risk assessment process and evidence was sighed in clinical documentation in each of the various wards and departments (both short and overnight stay units) and the Emergency Department. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The requirements of Advisory AS18/14 have been met by JFPH with the MDT Risk Screening Tool being introduced and continually updated since June 2019, to include screening for Cognitive Impairment/Delirium and the CIRAT tool along with all the risks described in the standard but also including VTE prophylaxis which is a significant improvement. In addition, there are several other forms and tools required to provide a smooth process of transfer from identification of risk to action to address risk by the MDT.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
JFPH clearly demonstrated that processes are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. This is audited, and compliance is around 1%. Identification is predominantly done at the reception/admission desk and these staff were able to describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin. Although there is only a small percentage of patients that identify as being of an Aboriginal and Torres Strait Islander heritage, the organisation has developed a relationship with the local Aboriginal Community and are trying to ensure a welcoming environment for Aboriginal and Torres Strait Islander people.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	
All patients are asked as part of the admission process if they have completed an advance care plan (ACP). If the patient does in fact have an ACP, a copy of the plan is put at the front of the medical history and a note of its presence is included on the Alert Sheet to minimise the risk of staff not being aware of this plan being in place. However, the number of patients without an ACP is high, and so the discussion is often raised with the key relatives (e.g., spouse, children) of patients about the patient's attitude towards what care they would wish to have, should the worst-case scenario occur.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive and holistic assessment is conducted on admission and repeated weekly or when indicated clinically by a change in the patient's condition/request. The process includes screening for a large range of risks for preventable harm, including cognitive impairment, medication management, malnutrition, falls, venous thromboembolism (VTE). Mental health, behavioural and substance withdrawal, and skin integrity/pressure injury risks, along with any social or other issues that may compound risk. Risk screening processes are regularly audited, and reports are provided through the organisation's governance structure. An extensive review of clinical documentation by the entire Assessment Team reinforced this. The requirements of Advisory AS18/14 have been met by JFPH with the MDT Risk Screening Tool being introduced and the use of "Track and Trigger" observation charts that clearly identify a physiological change in a patient's condition as well as charts that identify behavioural changes in a person's mental health. In addition, there are several other forms and tools that have been developed such as Department/Surgery specific Observation Charts, High-Risk Medication Checklists, Medication Management Plans, Comprehensive Care Plans and Clinical Pathways, as required, to minimise risk to the JFPH patient cohort.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Risks are identified using standardised and evidence-based screening tools which identify the level of risk and appropriate actions to mitigate them. These include the Waterlow Skin Integrity Tool, the Falls Risk Assessment Tool, the 4AT Cognitive Impairment/Delirium Assessment Tool to name a few.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to the identified risk. The four-page Healthscope (HSC) Comprehensive Risk Screening Tool contains instructions for staff on how to complete the risk screen and each page is divided into two columns; the left providing the risk indicators, and the right identifying what action needs to be taken to address any identified risk. The document is clear, simple, and easy to use, and staff filled these tools out very well. Where risks were identified, a referral to the appropriate MDT member was very timely, to minimise the risk of occurring for that patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Comments
Clinicians and patients were able to describe the role patients, carers and families play in their care and in determining patient centred goals and how it aims to best meet their specific needs. A review of clinical documentation by the Assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey and there were specific staff members whose role was to assist with the smooth transition at the time of discharge and this was very well done. Members of the assessment team witnessed interactions between staff, patients, their carers and families that demonstrated this partnership in care and decision making. Care plans reflect contemporary evidence-based best practice principles. • In addition, JFPH has initiated the "Back to Bedside" Program which includes: o Hourly patient rounding o Beside clinical handover o Bedside "Care Boards" for communication with the patient and their family o Standard communication methodology (AIDET) o Acts of kindness

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
The requirements of Advisory AS18/15 have been met by JFPH with the HSC Comprehensive Care Plan was initiated in September 2019 and has been modified as required to make an excellent Comprehensive Care Plan document with associated policies, procedures and forms.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	
Patients, their carers and families were able to articulate their level of engagement in their care and expressed satisfaction that they actively participated in decision making at all points of care and transition. Results of the "Qualtrix" patient satisfaction surveys clearly demonstrated that greater than 90% of patients felt the quality of their care was either "Very Good" or "Good" consistently throughout the past two years. Goals of care are monitored, and care planning is modified in response to changes in goals, changing clinical status needs or risk profile.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Comments	
Processes to define those patients at end-of-life are in place and staff interviewed were aware of these. The organisation has aligned its processes to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Discussions with either the patient or their family (dependent on the patient's condition and ability to contribute meaningfully to the discussion) are held to ensure the wishes of the patient either in the form of an ACD or just described verbally by "treatment-limiting orders" are met. This important and critical information is documented on the alert sheet at the front of the medical history so all staff are aware of the patient's/families' express wishes and will abide by them. Palliation services are provided to patients of the hospital if requested.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Comments	
The organisation has access to specialist palliative care services/advice through the staff Oncologists and the Nurse Unit Manager/nursing staff of the Oncology ward. Staff interviewed were aware how of how to access these services. Most palliative care is provided in a single room of the hospital rather than the Oncology ward mainly due to the need for Oncology patients requiring active chemotherapy treatment, but also to allow the patient and their family to remain in familiar surroundings with familiar staff with whom they and the family feel safe.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
A review of clinical documentation confirmed that advance care plans are documented in the patient's healthcare record, although as previously stated, these are relatively rare. Clinicians who were interviewed could describe the process in place to ensure that patients with an "Advance Care Directive or Plan" (ACD or ACP) are identified and that care is provided in accordance with these documents. At every Medical Emergency Team (MET) call, the team always first check the medical notes to ensure that if there are any ACD or Treatment-Limiting Orders (such as "Do not resuscitate") that these wishes are followed. When the MET was first initiated (years ago) some staff required education about this, but now all staff are aware of the need to comply with patients and families wishes in relation to acute physiological deterioration and just notify the treating clinician about the deterioration of the patient as well as the family/relatives.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
Supervision and support for staff providing end-of-life care are available through the HSC End-of-life Booklet and staff are aware of the staff debrief that follows any death within the hospital as well as how to access support services such as the Employee Assistance Program (EAP) if they require psychological assistance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	
Goals of care for patients at end-of-life are articulated in the clinical record and established in partnership with patients, their carers and families. The planned goals are reviewed regularly, and changes documented in the clinical record as they occur or are required. This information is also handed over to the following shifts, so all staff are aware of changes to the care plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Comments	
The organisation supports shared decision making about end-of-life care with patients, their carers and families. This is supported by regular communication and documented in the clinical record, and the assessors saw evidence of this in clinical documentation. Support for decision making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
The organisation has evidence-based policies and procedures for pressure injury prevention and wound management. These are well referenced and regularly reviewed. 0% hospital-acquired pressure injuries were reported over the first half of 2021 however there was one pressure injury that has occurred so far since the start of the second half of 2021. A quality improvement activity in the Critical Care Centre was aimed at eliminating pressure injuries related to the long term use of Nasogastric Tubes in ICU. This resulted in the elimination of these occurring since the project was implemented. An excellent example of staff working to achieve greater outcomes for the long term, critically unwell patients who are at a greater risk of developing pressure injuries. Another improvement was related to the purchase of beds for the ICU that had the ability to tilt the mattress to one side or another to enable the smooth and regular transfer of patients from one side to the other to enable effective pressure relief whilst unconscious and ventilated in ICU. Expensive purchase but magnificent outcomes for the patients of this department. All position changes are documented on a “turn chart” to ensure sign off related to each position change during each day which is audited and regularly reported.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Skin inspections are conducted in accordance with policy and compliance is reported as 100%. As stated above, this is monitored by regular auditing of the Risk Assessment Tool and of the Turn Charts within each department.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is available to patients, their carers/families about pressure injury prevention, this information is in a user-friendly format and staff were able to describe how they would use it. Equipment, products, and devices, including the tiltable ICU beds, air mattresses, and many other pressure-relieving devices are available to prevent and manage pressure injuries, and the Assessment Team witnessed these products in use across the hospital for patients who were at risk of developing pressure injuries. JFPH has a brochure for patients/families/carers about the "Prevention of Pressure Injuries" which has been consumer tested and approved meaning that this information is in a user-friendly format.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
Evidence-based policies and procedures include risk assessment, prevention, harm minimisation and post-falls management. Compliance with undertaking falls risk assessments and falls management action plans are audited and the results reflected compliance with falls risk screening at 100%. The JFPH falls rate currently sits at 0.27% for 2020 compared to the industry rate of 0.30%. Staff were able to describe strategies to minimise harm and clinical documentation reviewed by the Assessment team supported that this is undertaken comprehensively. Incident data related to falls is analysed and reported through the organisation's governance structure. Post fall management now includes attendance by the MET, with the assessment of a potential closed head injury being determined by a CT Head Scan, particularly if the patient is taking anticoagulants.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
Equipment, devices, and strategies to prevent falls and minimise harm from falls are available to staff. Members of the Assessment Team saw evidence of the use of these in accordance with the requirements of individual patients as identified on screening. These include Pharmacy medication review, relocating the patient to a room improving visibility (e.g., proximity to the nurse's station), bed/chair alarms, bathroom supervision at all times, regularly assisted toileting, patient's family/carer being allowed to stay overnight and in the worst-case scenario, use of individual patient special – staff member to stay with the patient at all times. JFPH have an Inpatient Specialling Care Assessment Tool to assist staff to determine if this option is appropriate to monitor high-risk falls patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
JFPH has a brochure for patients/families/carers about the "Falls Prevention and Risk Management Strategies" which has been consumer tested and approved meaning that this information is in a user-friendly format.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
Patients are assessed for nutritional needs and risk of malnutrition. Special dietary plans are established for those who require them and referrals to a dietitian are made where risks are identified. The Assessors saw evidence of screening and referral on review of records and interviews with staff confirmed their understanding of the process. The nutrition and hydration risk assessments are regularly audited and are completed 100% of the time.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Comments	
The organisation provides nutritional support to patients based on their specific needs that are identified through risk screening. Patients who are at risk of malnutrition or who require assistance with eating and/or drinking are provided with assistance. The service has access to specialist dietetic support for those patients identified as at-risk or with specific needs. Food and fluid intake is monitored and reported for those patients who are at risk of not having their nutritional needs met. A fluid balance chart is used to report fluid intake and output. Staff are required as part of their hourly rounding to assist patients with such things as opening single-use containers that patients find difficult to open to ensure they have access to all the food and fluid available to them for that meal. Patients told the Assessment team that they found the food always to be at the appropriate temperature and very nice and tasty to eat/drink.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Comments	
Cognition screening is undertaken on admission and as required throughout a patient's admission where clinically indicated. Evidence-based policies and procedures support staff in developing appropriate management/care plans and these strategies are reviewed for effectiveness. This includes the use and monitoring of medications to ensure compliance with best-practice standards. Screening rates are regularly audited and reported through the organisation's governance structure. The current compliance rate is 100% across JFPH. The organisation is compliant with the requirements of ACSQHC Fact Sheet 11 (5.29a). JFPH has: • Identified Delirium Clinical Care Standard relevant to its service context • Provided clinicians with access to the Delirium Clinical Care Standard • Provided relevant clinicians with its policy or protocols that identify the Quality Statements the organisation is responsible for indicators being monitored for the Delirium Clinical Care Standard • Implemented the requirements set out in the Quality Statements and are monitoring the Quality Statement indicators for the Delirium Clinical Care Standard.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
Documentation reviewed shows systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken and compliance with screening is reported at 100% currently. Staff were able to describe how they collaborate with patients, carers and families in caring for patients with cognitive impairment.

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
It is important for staff to know as much as they can about the patient with cognitive impairment such as their likes and dislikes, hobbies, former job/employment, any pet(s) or special people in their life, any authors or favourite movies/TV shows etc. This way they can change the topic to something they are familiar with if they start to become confused or agitated, to bring something relevant to the consciousness that distracts them from whatever is upsetting them and has been found to greatly reduce stress and anxiety for all concerned. Staff do this well and it is great to be able to visualise this in real life and see how this actually works to calm patients in distress.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
This is not anything that any long-time employees of JFPH have ever come across, but all staff agreed that they have a team of staff within the hospital with the skills to “de-escalate the situation” and be able to sit down and talk to these patients. JFPH have trained staff to become “Mental Health First Aiders” for both staff and patients, who exhibit mental health problematic behaviour such as self-harm and suicidality behaviour. There is a plan to train more staff so there is someone available on every shift in the future and this has gone a long way to aid in situations as described in this action. These staff are not “trained psychologists or mental health clinicians” but are educated on many aspects of mental health deterioration and what type of referral or action to implement if they feel the patient is at risk of self-harm, suicide, or other forms of violence/harm. Their job is to report if someone is at risk of hurting themselves or others and to refer to the family doctor or a psychologist if less urgent symptoms are present. The organisation has access to referral services through HSC Mental Health facilities and can call these for assistance and guidance on how to proceed with intervention strategies for patients at risk of self-harm and/or suicide.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Where patients have self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and referral service through the HSC Mental Health Facilities, and staff were able to describe how they would access and use these services according to local guides for services across Healthscope.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used. Code Grey/Black is used to notify the organisation of escalating aggression-related incidents.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
Comments
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used. These relate to the Code Grey/Black where a team of personnel trained in de-escalation techniques respond to any incidents of aggression, both verbal and/or physical. JHPH also has security staff on duty who can assist where necessary and can call 000 for police assistance if required or Mental Health assistance from the Mental Health Crisis Management Team if the patient has mental health problems.

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
HSC has policies and processes are in place to govern and manage the use of both chemical and physical restraint and these includes alternative strategies to minimise the use of restraint. These policies are consistent with the legislation and include processes for reviewing and reporting the use of restraint to the governing body.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Comments	
HSC has policies that support that seclusion is only used to prevent harm and its use is compliant with legislation, monitored at the individual patient level and aggregate level and reported to the governing body. However, JFPH is not a Mental Health Facility that is legislated to use seclusion, so this action has been rated as “Not applicable”.	
Rating	**Applicable HSF IDs**
NA	All

Standard 6 - Communicating for Safety

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

ACTION 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
There are eight Healthscope (HSC) policies and an additional 11 JFPH policies in place to support effective communication across all the various admission, transfer, discharge, and follow-up processes within JFPH. These policies identify risk management strategies to mitigate the known risks associated with the communication of clinical information. Staff have been educated in relation to effective communication as part of a Key Improvement Strategy called the “Back to Beside Program” which commenced in 2018 and set the expectation of all staff in support of effective clinical communication using defined processes. It was a Healthscope wide program, based on three components: • Rework • Always events • Feedback loop Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
Incidents relating to a failure in clinical communication are reported through the incident management system and identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover, is monitored through feedback and audit. The 'Back to the Bedside' Program was refreshed, and staff were retrained in 2021 with the introduction of the STA2T communication tool – Standard Communication Tool Clinical and Non-Clinical. Staff were educated about "Always" events. These are the key behaviours that patients told JFPH impacted their hospital experience. For nursing staff these were: • Standardised communication (AIDET) • Patient rounding • Bedside handover • Patient care boards • Acts of kindness All patients are asked for an email address at the time of admission so that a post-discharge "Qualtrix" survey could be emailed to them to complete. The response rate was very high and provided the organisation with significant feedback related to patients' impressions of the care they received whilst an inpatient/outpatient at the hospital. The Assessors viewed trended results of these Qualtrix Patient Feedback Surveys which are conducted continuously and have been since January 2018. The overall results although fluctuating consistently over time, show consistently high results around the mid to high 70% range. This program is a truly 'Patient Centred Care' initiative that has yielded excellent feedback from consumers of the services provided by JFPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation has a policy that supports the engagement of patients, their carers and families in their own care and shared decision making. Patients are involved in clinical handover and the Assessors witnessed handover supporting this in the ED, wards, operating suites and outpatient departments. On the wards, the patient care board was used as a method to communicate with the patient's family and/or the patient themselves. Patients who were interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care. Much of the information provided for patients had been "certified" by the Consumer Consultants to ensure readability and appropriate diagrams or photographs to simplify the information for all consumers, as JFPH has a large NESB cohort of patients. Clinicians were overheard to take the time and effort to explain all the options patients had available to them, along with the benefits, risks and costs associated with each option. The patients were encouraged to actively participate in the decision-making process once they felt they fully understood the associated factors associated with each option.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes are in place to support appropriate identifiers are used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care/patient risk profile are identified. Documentation viewed by the Assessors supports the use of specified identifiers in all of these situations.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
The organisation has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the Assessors witnessed this when observing clerical staff admitting patients to the hospital whether as an inpatient or an outpatient, using at least 3-4 unique identifiers to ensure they had the correct patient. In addition, the assessors also observed any staff member administering medication(s) or IV fluids again checked the patient's identification against their ID bracelet and the medication/IV order sheet prior to administering the medication or commencing the infusion. Also observed were Pathology and Radiology staff undertake the full patient identification procedure prior to commencing venepuncture or radiological examination.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
The Assessors noted the use of approved patient identifiers as noted in Action 6.5. Additionally, processes are in place for surgical/procedural time-out, and this is documented and audited, with compliance at between 98-100%. A limited review of clinical documentation supported these findings. Assessors observed a formal "Time out" occurred prior to any procedure being conducted on a patient and particularly a "Team Time Out" occurred with all members of staff in the operating suite prior to the patient being sedated or anaesthetised. In all the above observations, allergies, ADRs and other critical patient-related information were highlighted to those checking to ensure this vital information was transferred and known by all involved in the process. The associated documentation viewed by the Assessors supports the use of the specified unique identifiers in each of these situations.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient, and the clinicians involved in the handover. Compliance with these requirements is audited and reported within the governance structure and the current compliance rate is between 80—100% for the components of the total clinical handover process. There were only three areas in which 100% compliance was not achieved (Aug21) and these areas were – introduction to the patient (88%), handover addressed discharge needs (82%) and handover included patient and/or carer (94%). The JFPH uses the ISBAR acronym for all clinical handovers of information. Staff could explain their respective roles in clinical handover the processes used to support this including the minimum information communicated at clinical handover. This supported the clinical handovers witnessed by members of the Assessment Team.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.8
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
The assessment team witnessed clinical handovers that were structured using the ISBAR tool and were witness to the effective engagement with patients, their carers and families in defining goals of care and decision making. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learned, shared and disseminated via the governance structure.

ACTION 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Comments	
Both HSC and JFPH have policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. This is evident particularly in relation to allergies and ADRs, but also to any medications, diseases, infections, medical conditions, treatments being undertaken etc. that may put the patient at higher risk of complications or other adverse events. Both patients and staff were able to describe to the Assessors how this worked and how patients, their carers and families were involved when they wanted/needed to be. Clinical handover is regularly audited, and any clinical incidents or feedback received from patients/relatives related to communication issues are addressed appropriately and lessons learned are shared within the hospital but also across Healthscope.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. As part of the “Back to Bedside Program”, the patient and the family are invited to share any information or ask any questions using the Patient Care Boards to communicate important information to clinicians and staff. The main things the hospital encouraged to report were: • Recent changes to medications • Any diagnostic tests they had undergone • Perceived clinical deterioration of the patient • Change in the patient’s goals • Anything else that was important to the patient or the family Clinicians and patients/carers interviewed confirmed this and the Assessors observed information available to support and facilitate this process. One example included one patient wanting to know if he had to go back on chemotherapy after having surgery for his cancer. The family had also added a question for the doctors about when the patient was expected to be discharged now that he had undergone surgery.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
Clinical documentation reviewed by the Assessors confirmed compliance with the organisation's process to ensure complete, accurate and up-to-date information is recorded in the healthcare record. Members of the clinical team could describe this process. Comprehensive clinical documentation audits are conducted very regularly and currently are being conducted monthly due to a large turnover of staff during the Pandemic to ensure immediate feedback to new staff regarding the expectations of the organisation into excellent documentation of patient-related information and in particular critical information.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

ACTION 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
Policies and procedures consistent with the organisation's safety and quality systems are in place for blood management and the management of associated risks. Two pathology laboratories are co-located with the hospital, and the organisations work closely together. Incidents and risks are reported through RiskMan. One example of managing risk is the correct patient identification, where all samples are labelled at the bedside with handwritten labels. Another example is the modifications to the Blood and blood products prescription and transfusion form which assist with reducing potential transcribing errors. The blood fridge is located in the Critical Care Complex (CCC) and is accessible at all times. BloodSafe training is provided to eligible clinical staff with compliance reported at 86% in the 3rd quarter of 2021.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Comments
The organisation monitors the blood management process in terms of blood and blood product utilisation, quality and safety and patient outcomes. The JFPH Blood Management Working Party oversees blood management, and reports data through the Quality and Risk Management Framework to Clinical Governance, the Nursing Leadership Group and the Quality Consumer Forum.

ACTION 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Implementing strategies to improve blood management and associated processes has included an emphasis on clear documentation if irradiated blood is required. A Massive Transfusion Resource Folder was introduced in 2020. There is one at the blood fridge and the other is in the operating theatre complex. This includes pre-printed pathology request forms and associated pathology tubes, as well as role cards for members of the Massive Transfusion Team. Following the blood fridge register audit January – December 2020, results showed that the time was documented 60% of the time. This resulted in the register being redesigned. Infusion pumps with hard and soft limits are used. Outcomes of blood management include reporting to Healthscope quarterly, and these are benchmarked. There are also reports to internal committees including the Medical Advisory Committee and Clinical Governance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.3
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
The organisation supports the engagement of consumers in care related to blood management including informed decision making and patients were observed to be actively involved in their own care. Patient brochures are available in 18 languages. Patients who had received blood / blood products were available for interview and confirmed their engagement in informed consent. 100% of patients in the 2020 consent audit said that they received enough information about having a transfusion. However, audits conducted in the 2nd and 3rd quarters of 2021, indicated that 6.67% of transfusions were given without the consent form being completed. There is shared decision-making, and a consent process for frequently transfused patients which remains valid for 12 months is used unless there is a significant change in the indication or risk profile.

ACTION 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Suggestion(s) for Improvement	
Staff education and targeted conversations with medical staff to continue to reduce the percentage of transfusions without consent documentation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
The organisations processes and policies support the clinically effective and efficient use of blood and blood products. Utilisation is monitored and action has been taken to minimise wastage and the inappropriate use of blood and blood products which is reported through the JFPH Blood Management Working Party to the Clinical Governance Committee. Optimising patients' blood requirements was studied for patients with patients having a total knee replacement. The intervention strategy resulted in iron studies including ferritin going from 0% to 100%. Identifying and managing patients with, or at risk of bleeding has resulted in measures such as use of tranexamic acid intraoperatively in major orthopaedic surgery to minimise transfusion and peri-operative assessments of patients taking anticoagulants. Determining the clinical need for blood and blood products has resulted in the display around the hospital of the poster providing education about the benefits of single unit transfusion.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
The Assessors reviewed a limited number of transfusion records in the clinical records and found evidence to support the effective documentation of decision making and transfusion details. This is supported by regular audit of transfusion records. Prescriber documentation compliance with the Blood and blood products prescription and transfusion record was 99.5% in the 2020-2021 audit.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
Policies consistent with the national guidelines and national criteria for the prescription and administration of blood and blood products are in place and available to clinicians.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.7
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria
Comments
Policies and processes are in place to support compliant reporting of adverse events related to transfusions. These are monitored and reported through the Blood Management Working Party, which reports serious incidents to relevant committees such as the Medical Advisory Committee and the Clinical Governance Committee. There have been no adverse outcomes relating to blood transfusions since 2014. There have been no incidents related to blood sample collection errors over the past year 2020; and 11 incidents recorded in RiskMan January -December 2020.

ACTION 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
The organisation contributes to haemovigilance activities including reporting incidents externally to Blood Matters. Policies cover all aspects of blood use and reporting of transfusion related issues internally.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
Blood and blood products are stored, distributed and managed in compliance with legislative and regulatory requirements and are able to be traced. Processes are monitored and reported through the Blood Management Working Party. The audit June 2021 showed a compliance of 100% for all aspects of blood fridge compliance. Any incidents related to inappropriate handling of blood or blood products is reported and managed through Riskman, the incident management system. It was observed by assessors that the system in place ensured that blood and blood products could be traced from entry into the organisation to transfusion, discard or transfer.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
Processes are in place to manage the availability of blood and blood products, eliminate wastage and respond to shortages. The use of blood and blood products is monitored and reported through governance reporting mechanisms. The availability of blood products is managed by the two pathology laboratories which are located close to the hospital. All wastage is reviewed by the transfusion nurse consultant and reported at the relevant meetings. Pathology staff check the blood fridge daily and return unused blood to the laboratory inventory for use by another patient. Response in times of shortage includes rapidly alerting pathology if a massive transfusion is required, and group and holds only being dispensed from the pathology laboratory when required.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

ACTION 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
Both Healthscope (HSC) and JFPH policies and procedures are in place for recognising and responding to acute deterioration (RRAD) and staff were able to describe their role in such events. These policies and procedures covered all aspects of acute physiological deterioration and also covered delirium and cognitive impairment. Governance of risks and training needs related to RRAD were identified and monitored by the RRAD Committee, which reports up to the Medical Advisory Committee (MAC). From this point, MAC reports up to the Clinical Governance Committee (CGC) and to the Heads of Units. The RRAD Committee also monitors the utilisation of the adult “Track and Trigger Observation Charts”, and HSC has developed their own “Track and Trigger Observation Charts for the specific child age groups of 1-4, 5-11 and over 12 years of age. These observation charts are designed to “trigger” a MET call to ensure early intervention of what could be a serious outcome for the patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Comments
Systems are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration and this is reported through the RRAD Committee and to clinicians for the purposes of clinical review. In response to incidents related to clinical deterioration improvements have been made including: • Operation Risky – where the ICU NUM checked all the MET and Code Blue logbooks to see if a RiskMan incident had been completed for each call. This review identified that only 40-50% of MET/Code Blue Calls had been put into RiskMan and a concerted effort has now led to >85% of calls now recorded in this database • Paediatric MET call & using the age-specific observation charts and a Paediatric Resuscitation trolley to attend all these calls

ACTION 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
• MET Call now made for patients who fall and strike their head – especially if on anticoagulant therapy • Code “Stroke” • Code “Chest Pain” • Sepsis Pathway • Mental Health Pathway – link to Melbourne Clinic and North Park Private Mental Health Care Facilities	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making	
Comments	
HSC and JFPH documents, brochures and pamphlets show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. Both patients and their families/carers are encouraged to ring for assistance or talk to the nurse looking after the patient if they are at all worried about their condition, as they know the patient best, especially parents with young children. This process includes involving patients, meeting their information needs and shared decision making. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration. The Assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients particularly in relation to the Patient Care Boards at the side or end of each patient’s bed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital signs are monitored according to policy using the HSC/JFPH "Track and Trigger" observation chart relative to the age of the patient (Adult, 0-4 years, 5-11 years and 12+ years) and a review of clinical documentation supported this as did regular auditing of clinical documentation. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation/intervention. Initially, staff were reluctant to call a MET, but with the assistance of the Nurse Educators and ICU and ED Nursing Staff who attend these calls, nursing staff now have been praised for raising the alarm and helping to prevent further physiological deterioration in their patient's condition. Together with the inclusion of these ward nursing staff with the assessment and treatment of the patient on the ward has raised the awareness and comfort of ward staff to raise a MET call and this has reportedly prevented many worse scenarios from occurring. The ICU, ED and Nurse Educator staff have done a great job of teaching and encouraging the general nursing population of JFPH and deserve recognition for all their efforts in this area.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.5
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
Policies and procedures support staff in identifying acute deterioration in mental state including the risk of delirium which is not very uncommon. Assessment and care planning documentation reviewed by the Assessors also supported that assessment drives the establishment of individualised and appropriate and management plans for patients with acute mental deterioration and/or delirium although mental health deterioration has been relatively rare in this organisation to date.

ACTION 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
JFPH as part of Healthscope has the advantage of having close ties with two local mental health facilities run by HSC, namely the Melbourne Clinic and North Park Private Hospital. This provides the staff of JFPH the ability to tap into these two local Mental Health facilities to obtain guidance and support should a mental health crisis arise and if a bed is available, transfer to either one of these two facilities can quickly be arranged and facilitated. For less severe mental health-related problems, JFPH has trained up 6 senior nursing staff as "Mental Health First Aiders" and have developed a "Mental Health First Aid Flow Chart" when staff recognise an active mental health concern that is affecting the current admission. In addition, all JFPH clinical staff are required to undertake "WAVE training" which involves de-escalation of disruptive behaviours. Any suicidal ideation triggers a rapid response at JFPH. Clinical documentation is regularly audited and compliance with cognition screening is reported as 100%. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members as detailed in Standard 6. The requirements if Advisory AS 19/01 has been met in relation to this action: • The comprehensive care plan including the screening for risks of cognitive impairment or delirium is completed for every admission to JFPH • The comprehensive care plan is developed to meet the individual patient's health needs in alignment with their stated values, goals and preferences • Includes protocols for escalating care to the workforce with appropriate expertise to manage physiological or psychological conditions related to changes in their mental state • Staff complete HMR 6.27 Behaviour Chart which indicates improvement or further deterioration in the patient's mental health	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Comments	
Staff at JFPH monitor the performance of the identification and management of acute physiological, mental status, pain and/or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. This is predominantly done via the RRAD and the Morbidity and Mortality Committees. Staff interviewed were aware of these processes and able to describe them to members of the Assessment Team, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. The requirements if Advisory AS 19/01 have been met (8.6 b, c, d, e). • Agreed indicators of deterioration in mental state can be found on the 4AT assessment test for delirium & cognitive impairment, as well as the HMR 000 Alert Sheet (Mental Health Risks and Violence/Aggressive Behaviour Form) and Family/Carer Consultation Form HMR 6.28) • Agreed parameters and other indicators for calling emergency assistance can be found on the HSC Delirium Screen and the Cognitive Impairment Risk Assessment Tool (C.I.R.A.T) • Patient pain or distress that is not able to be managed using available treatment • Worry or concern in members of the workforce (policy on Clinical Deterioration and Recognising and Responding to Acute Deterioration), patients, carers, and families about acute deterioration (Policy on Rapid Response by Patient, family or carer).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers or families to directly escalate care facilitated by the policy on Rapid Response by Patient, family or carer and include information on the Patient Care Boards as to how relatives can do this. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Though the numbers of patient/relative/carer escalations are not high, they do exist supporting the organisation's efforts to encourage this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and the Assessors were provided with documentation to support the evaluation of these processes which are reported through the RRAD committee as described under Action 8.1.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff were able to describe the systems in place to escalate care consistent with the organisation's policy. Reports provided to the Assessment team and reported through the RRAD Committee confirmed the effectiveness of these processes. The success of this program continues to grow as more and more staff get actively involved with MET and Code Blue calls on the wards and within the grounds of the hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. Compliance with training is reported as 100% and this is mainly driven by the ICU Intensivists and the ED FACEMS who attend Code Blue calls. All these clinicians are extremely competent at Advanced Life Support (ALS) (Level 1). ICU and ED Nursing staff are all educated in ALS and the nursing educators across the organisation train all nursing staff in Basic Life Support (BLS) using their very impressive 'CPR' dummy which can simulate breaths, sighs, vomiting etc. The educators and nursing staff report that using this more 'life-like' dummy makes the process more realistic and memorable. During the pandemic, with many staff shortages, not all nursing staff have been able to be trained face-to-face in BLS, but all staff have undertaken eLearning in this area. As nursing staff are replaced and with some restrictions being lifted, the face-to-face training will begin again in earnest in the very near future. In addition, and as stated previously, JFPH has trained six senior nursing staff as well as 'Mental Health First Aiders' and a further rollout of this program of education is planned for 2022.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency as described under Action 8.10. Training records were made available to the Assessors with compliance at 100%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. This is facilitated by close links to other Healthscope facilities with Mental Health services, namely the Melbourne Clinic and North Park Private Hospital. If neither of these two facilities has a bed the patient can be transferred to, then referral to the Public Mental Health sector is arranged. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS 19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to members of the Assessment Team and the effectiveness of escalation of care processes are monitored through the RRAD Committee. This occurrence is relatively rare unless the ICU/CCU Centre is full with no patient able to be transferred to a normal ward bed. If this would occur, there are other Healthscope hospitals in the region with large ICUs and failing that option, patients would be referred to one of the large public hospitals with suitable facilities. Many of the VMOs that work at JFPH also work in these large public tertiary referral facilities and due to their contacts, can facilitate urgent transfer if the patient is critically unwell.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil