Report of the ACHS EQuIPNational Organisation Wide Survey

Sunnybank Private Hospital

Sunnybank, Qld

Organisation Code: 72 17 58

Survey Date: 20-22 September 2016

ACHS Accreditation Status: ACCREDITED

Table of Contents

About The Australian Council on Healthcare Standards

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

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

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

1. a customer focus
2. strong leadership
3. a culture of improving
4. evidence of outcomes
5. striving for best practice.

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

What is Accreditation?

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

How to Use this Survey Report

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

1. provide feedback to staff
2. identify where improvements are needed
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.

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

1 Survey Team Summary Report
2 Action Ratings Summary Report
3 Summary of Recommendations from the Current Survey
4 Recommendations from the Previous Survey
5 Standard Ratings Summary Report

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

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

Action Recommendations

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

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

1. E: extreme 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

2 Actions Ratings Summary Report

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

3 Summary of Recommendations from the Current Survey

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

Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

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

The action numbering relates to the month and year of survey and the action number. For example recommendation number OWS 0613. 1.1.1 is a recommendation from an OWS conducted in June 2013 with an action number of 1.1.1,

5 Standards Ratings Summary Report

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

Survey Report

Survey Overview

Sunnybank Private Hospital (SPH) is a small, quiet private hospital with a largely elective surgical casemix located in a south Brisbane suburb, in close proximity to a number of larger public and private tertiary hospitals. In preparation for expanding its maternity business and introducing a range of new services a major renovation and building program is underway.

A new executive team, including many Nurse Unit Managers (NUMs) and created over the last eighteen months, is leading the organisation to new heights in safety, quality and activity.

The organisation provided surveyors with a comprehensive self-assessment and they were given the opportunity to visit all clinical areas. In addition, the survey team met with SPH executives and numerous clinical and non-clinical staff. The surveyors also met with Visiting Medical Officers (VMOs) who were active members of the Medical Advisory Committee. The surveyors were also given access to extensive policies, procedures and other relevant documents.

The surveyors noted major building works taking place on site and the restrictions construction programs such as this can place on patients attending the organisation for care and for staff coming to work. To minimise inconvenience numerous initiatives were in place to optimise patient and staff comfort and safety during the lengthy building period and patient satisfaction surveys testify to the success of the support program in place.

The new executive team has worked tirelessly to build a culture of safety and quality and is starting to see positive results on all parameters. Consequently the organisation's risk management and quality frameworks are robust and attention to quality and safety is much in evidence. There is evidence of an organisation which is increasingly understanding the importance of audit and evaluation which has contributed to ongoing quality improvement across the fifteen EQuIP National standards.

The surveyors noted that staff are now provided with, and take advantage of, numerous opportunities for education, training and professional development. They were uniformly very proud of their organisation and its growing achievements.

There were no recommendations from previous survey. Two new recommendations have been made regarding improving governance in medication safety and aseptic technique training.

Two actions have been rated Met with Merit (MM) having met the rigorous requirements to do so.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Sunnybank Private Hospital is a well-governed organisation with effective systems in place at the local level, with the support of an ACHS accredited corporate entity, to develop, implement and oversee an extensive suite of policies and procedures which guide quality and safety. Examples were provided where business decision-making has taken patient safety and quality of care into account, including in regard to the extensive building program currently underway. Safety and quality indicators are regularly reported to the hospital executive, and to the company Board of Directors; action plans are developed and monitored when indicators fall below expected standards.

The workforce is aware of its responsibilities in regard to safety and quality and surveyors noted an improving culture in regard to reviewing performance and implementing changes in practice to benefit patients. Similarly there are systems in place to ensure that the agency workforce understand their obligations. Emphasis is placed on quality and safety in orientation and training programs, and all staff receive mandatory annual training in how to meet the Standards. An integrated risk register is in use and regularly reviewed, with risks rated, mitigated and monitored for status change. Led by the new executive team there is an evolving culture of risk minimisation and quality improvement. A comprehensive organisation-wide quality management system is in place with an extensive portfolio of quality activities underway to maximise patient quality of care.

Clinical practice

Agreed and well-documented clinical policies and procedural guidelines exist to help clinical staff. These are readily accessible on the Healthscope corporate clinical intranet (HINT). There are a number of regular audits in place that assist in monitoring compliance by clinical staff with agreed clinical policies.

There is an awareness of the need to monitor patients at risk of increased harm. This monitoring begins with the risk ratings incorporated into the admission process about risks of falling and skin integrity.

There is now a well-developed and regularly monitored system in place that monitors the need to escalate the level of clinical care as a result of any sudden deterioration in the patient levels. There are proven policies in place and the use of track and trigger charts. The supervision, training and feedback discussions provided by the on-site Critical Care specialist staff has had a significant effect on getting this system working well. There is now very good and timely feedback to involved staff following any sudden deterioration event.

Effective policies are in place to guide facets of medical record keeping. Current records are well kept, contain adequate detail; are fully integrated; and have all diagnostic results included. The clinical records are well-used by clinical staff and are useful clinical communication instruments. The clinical records in use at this health service are suitably designed to allow documentation and clinical content auditing.

Performance and skills management

The scope of clinical practice is kept under regular review by the health service management to ensure that the clinical workforce skills remain consistent with the patient mix. Job descriptions are carefully reviewed prior to recruiting new members of staff.

Appropriate attention is directed towards ensuring that staff credentials and scope of practice remain relevant.

An effective performance review process is in place and carried out each year for all staff members. Staff educational needs and career development issues are integrated into the process. All staff are regularly provided with educational sessions about quality and risk issues.

Regular feedback from staff is garnered and regarded as important. This feedback is achieved, for example, by way of staff satisfaction surveys, and as a by-product of the performance review process.

Incident and complaints management

Corporate policies covering all aspects of incidents and complaints, their reporting, resolution and management are in place. Root cause analysis and open disclosure are also covered.

Incidents and complaints are reported on RiskMan software. Reporting of incidents and complaints is very much encouraged at this health service and the survey team noted that a culture of reporting is largely in place throughout the health service. It is evident that all such reports are taken very seriously. Corporate KPIs require response to the complainant within 48 hours and wherever possible, resolution and feedback to complainant within 28 days. These KPIs are audited and closely monitored. Sentinel events and Shared Learnings reports generated at corporate level are fed out to health services each three months and require the GM and DON to sign off on how they have reviewed this health service and what action, if any, has been taken as a result of the learnings of the combined health services.

All new staff are introduced to the RiskMan system and shown how to use it. Use of the system is promoted through regular e-bulletins issued by the GM. All reports made on the RiskMan system are analysed and the results are fed to the senior clinical committees, corporate, the Medical Advisory Committee and Quality and Risk. Reports of a very serious nature are escalated to corporate level and the possibility of root cause analysis is provided. Staff are encouraged to involve patients and their families in resolving complaint issues.

Open disclosure based on the National Open Disclosure policy and process is being implemented. Most staff have received their open disclosure training. The survey team found that there was a good understanding of open disclosure amongst staff and the need to promote same.

Patient rights and engagement

There is an approved Charter of Patient Rights and a copy is placed in each bedside compendium. Nursing staff discuss patient rights with patients, especially if there are questions from the patients.

It is clear from written evidence, ward visits, discussions with individual patients and staff members, as well as from observation of a number of bedside handover events that patients at this health service are very much involved in decisions about their own health care.

Where a patient has an advance health care directive a copy is taken and placed at the front of the health care record. A notation is also added to the alert sheet. Advice is also given to patients on how to go about putting an advance health care directive in place for themselves.

Patient clinical care records are kept close to the point of health care delivery and are readily accessed by clinical staff. Observation and drug order charts are kept at the end of the patient's bed. Privacy of these records is well understood and inappropriate access to clinical records is not allowed.

Audits on, and reported incidents around, patient care are all well analysed and reported to patient care review committees. The result of this activity has led to improvements in delivery of health care and demonstrably better health outcomes.

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Healthscope has an established Corporate Consumer Advisory Committee (CAC) that functions as the peak consumer body to provide a consumer, carer and community member perspective with regard to planning, policy, service development and improvement across Healthscope facilities.

The Corporate Consumer Consultants actively participate in governance by providing feedback and recommendations on key documents including the Healthscope corporate plan; policies, procedures, clinical practice standards and patient education/information. The CAC Terms of Reference support targeted and effective consumer participation in service planning and review.

Sunnybank Private Hospital (SPH) has recruited consumer consultants that play an important role in connecting with patients and their carers at the local level. The local consultants have a current position description and attended a comprehensive orientation program in May 2015. At this point in time SPH has two consumer consultants actively engaged and it is suggested that a plan be developed to recruit additional consumers in order to sustain local involvement and that reflect the SPH patient demographic; for example, a consumer with Chinese origins.

Healthscope has established a robust process for the development and review of consumer information brochures. All brochures are reviewed by the CAC with feedback provided incorporated into the new brochures. The SPH consumer consultants review local information and protocols during the development stage and support the implementation of new initiatives, such as the PACE card.

Consumer partnership in designing care

Patient feedback, audit and review systems support design/redesign projects and quality improvement activities across the organisation and these are being utilised effectively. A number of initiatives have provided valuable feedback that can be applied to improve the patient experience. Good examples include the annual HCAPS patient-centred experience survey, inpatient focus group meetings such as the Oncology Service focus group, individual patient interviews and the recent involvement of consumer consultants in the design and refurbishment of patient rooms. It is suggested that feedback from the local inpatient focus groups and individual interviews be collated thematically and an action plan developed.

All staff are required to complete Patient Centred Care (PCC) training by attending a face to face workshop or completing the on-line e-Learning module on an annual basis. The training covers the principles and elements of patient- centred care, advice on how to encourage patients to be partners in their care, and the resulting benefits for patients and staff. The Consumer Consultants have been invited to participate in the monthly staff orientation program to present information relating to Partnering with Consumers.

Consumer partnership in service measurement and evaluation

The CAC is provided with meaningful and relevant information relating to Healthscope's safety and quality performance. The CAC is actively involved in the implementation of quality activities relating to patient feedback. The MyHealthscope website provides access to information regarding safety and quality performance.

The CAC has access to data relating to compliments and complaints and works to constructively address how issues and concerns can be addressed through input into quality improvement initiatives. Local consumer consultants participate in the SPH Quality and Safety Meetings.

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Governance and systems around infection prevention, control and surveillance at Sunnybank Private Hospital (SPH) work within Healthscope corporate governance and systems. SPH subscribes to an expert external infection control company (HICMR) and this provides access to their policy and procedure manuals; participation in their audit program, and tools. All policies and procedures are available to staff via the company portal and SPH Intranet. The HICMR - Total Hospital Infection Control Audit carried out in May 2016 found SPH 'Compliant' with nil recommendations.

It was noted by surveyors that policy 11.01 Expressed Breast Milk (EBM) does not address the current use of in-room fridges and the potential for mothers to store EBM in them as they are convenient. It is suggested that education provided to mothers be updated to direct them to store their EBM in the special fridge in the nursery.

Infection prevention and control strategies

The HICMR audit completed in May 2016 identified SPH as fully compliant with nil recommendations. A program of regular audits is in place. Results are analysed, trended and reported to the SPH executive, MAC and Healthscope. Feedback is provided to staff. Action is taken where needed with changes and improvements monitored for effectiveness. Hand hygiene education and compliance monitoring are undertaken on a continual basis. Medical staff are expected to provide proof of having completed hand hygiene training. Visiting Medical Officers (VMOs) are expected to provide evidence of complying with hand hygiene education requirements. Staff receive feedback on compliance. Education on preventing and controlling infections is provided to all clinical staff.

Managing patients with infections or colonisations

A framework of policies, procedures and guidelines is available to guide staff. Isolation rooms are available. Clinicians and kitchen staff receive education on the requirements for safe care of an infectious patient. Ongoing education is provided to staff. Patients are assessed in relation to infection risk and history at admission.

Antimicrobial stewardship

SPH has an Antimicrobial Stewardship (AMS) program in place. VMOs and staff have been educated on the requirements of AMS. Therapeutic guidelines and other Information are available for all clinicians. The program is evaluated and steps taken to improve compliance. Antimicrobial usage and resistance are monitored. Some medical staff are yet to fully engage in the AMS program.

Cleaning, disinfection and sterilisation

The cleaning, disinfection and sterilisation at SPH is undertaken in accordance with HICMR policies, procedures and auditing requirements, all of which meet the requirements of Australian Standard 4187. The outcomes of audits are evaluated and improvements made to address recommendations. Cleaning schedules are in place and cleaning is done by SPH staff. Cleaning practices are audited and evaluated. An example of a change to cleaning practices was the use of microfibre products that removed the need for buckets and reduced the heaviness of floor cleaning. It is suggested that a formal evaluation of the change be undertaken when a suitable implementation period has been in place.

The central sterilising supply unit (CSSU) and operating theatres work within the HICMR standards. Regular audits are undertaken. A high level of compliance is achieved. All scopes are reviewed annually by HICMR. New cleaning protocols have been introduced to meet industry best practice. Staff indicated that there is a scope replacement program in place. The hospital is undergoing extensive redevelopment and this includes the CSSU and OT areas. Staff are looking forward to new sterilising equipment and an instrument tracking system. Instrument tracking still currently relies on a lot of manual labelling and tracking. The new equipment will increase the level of compliance with AS 4178-14, for which a gap analysis has been undertaken and a plan developed.

Communicating with patients and carers

The 'My Healthscope' web page provides information to the community on SPH infection rates and compares them to other health organisations. Information and education is provided to patients and their carers, and is extensively displayed throughout the hospital. Hand cleaning solution stations are frequently available within the hospital.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

At survey approximately 70% of relevant clinical staff were trained in aseptic technique, thereby meeting requirements for transitional arrangements for 2016

Surveyor's Recommendation:

Ensure full compliance with aseptic technique training for relevant clinical staff.

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

There is an effective system of governance over medication safety at Sunnybank Private Hospital (SPH). Systems of control include a linear committee structure with appropriate lines of reporting via Medication Safety, Quality and Safety and Patient Review Committees to the Medical Advisory Committee and overseen by the corporate office, which also hosts a company-wide medication safety cluster in which SPH participates.

A comprehensive system of policies and procedures, consistent with legislation, national, jurisdictional and professional guidelines, oversees practice. However, surveyors noted that a recent failure of governance in the Operating Suite, where non-compliant, potentially unsafe practice by a small number of anaesthetists was observed, although immediately addressed by management, as yet has no monitoring system in place to ensure future compliance. A recommendation to this end has been made.

The medication management system is regularly assessed, including review of risks in this area. When risks are identified, a process is in place to develop and monitor mitigation action plans, with several examples provided to surveyors.

Adequate processes are in place to verify that the clinical workforce has medication authorities appropriate to their scope of practice, including monitoring mechanisms to ensure compliance.

Medication incidents are appropriately monitored, reported and investigated. A number of serious incidents have been logged in recent years but surveyors noted that contributing factors in each have been aggressively addressed, with extensive education, system changes (including physical upgrades) and improved monitoring, leading to pleasing outcomes in the reduction of medication incidents.

Several quality improvement activities were observed to be currently underway.

To further enhance governance in regard to medication safety, it is suggested that the organisation take steps to improve consistency in the timely sign-off of telephone orders by Visiting Medical Officers in the Maternity Unit and to encourage medical representation on the Medication Safety Committee.

Documentation of patient information

The recording of a best possible medication history is standard practice with appropriate education in place to ensure that this occurs effectively. The recent introduction of a medication risk assessment process has improved documentation and the new form is being increasingly well completed; patients scoring highly at assessment are referred to pharmacists for expert management from admission through to discharge. This information is available at the point of care.

Allergies and adverse drug reactions are also routinely documented in the patient clinical record, confirmed through an ongoing audit process. A system is in place to report adverse drug reactions to the Therapeutic Goods Administration.

Current medicines are now documented and reconciled at admission and transfer of care between health care settings.

Medication management processes

Information and decision support tools for medicines are electronically available to the clinical workforce at the point of care, and their use is reviewed. It is suggested that this process be formally recorded in the Medication Safety Committee minutes to acknowledge that this takes place.

Much work has been undertaken in regard to ensuring that medicines are distributed and stored securely and safely. The surveyors noted the purchase of new compliant drug fridges; dangerous drug storage systems, and the creation of new medication workrooms. All temperature-sensitive medicines are now appropriately stored with effective monitoring systems in place.

Effective systems of control, consistent with legislative and jurisdictional requirements, are in place in regard to the management of unused, unwanted and expired medicines.

The organisation has put considerable focus on improving the management of high-risk medicines including the introduction of proprietary safer pharmacy shelving systems, tall man lettering and revising the locations of many designated so-called PINCH (including potassium, insulin, narcotics, chemotherapy and heparin/anticoagulants) medications.

Continuity of medication management

A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines, including a visit by pharmacists to all patients/carers on discharge.

Information on medications is now routinely included as part of clinical handover and compliance with this action has improved over time through a range of quality improvement initiatives.

Communicating with patients and carers

Patients are provided with comprehensive information in regard to medicine management which is available in a range of relevant languages. This is readily available to the clinical workforce in either pamphlet format or via electronic means.

Audits indicate that an agreed medication management plan is documented and available in the patient's clinical record and that information provided is understood and meaningful to patients as determined through patient feedback.

Governance and systems for medication safety

Ratings

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

Action 4.1.1 Core

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

Surveyor Comment:

While compliance with policies and procedures in the Operating Suite is generally of a high standard a small cohort of anaesthetists was engaged in a potentially unsafe medication management practice which was also in contravention of the Australian and New Zealand College of Anaesthetists (ANZCA) guidelines. On discovery this was immediately addressed by management. However no monitoring mechanisms are in place to ensure ongoing compliance.

Surveyor's Recommendation:

Introduce a monitoring mechanism to ensure ongoing compliance with medication safety policy and ANZCA guidelines in the Operating Suite in regard to this practice.

Risk Level: Low

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

SPH has an effective patient identification system in place. The practice is to use four identifiers in accordance with Healthscope policy. Compliance with policies and procedures (PP) and National Standards is regularly monitored.

The latest audit of consent in 2016 found SPH 100% compliant. Any issue is reported to RiskMan, investigated, and quality improvements made. One event described involved a unit of blood sent from a pathology service bearing an unfamiliar UR number, being that of the pathology providers. Staff refused to administer the blood and took the matter up with the pathology service which has now agreed to discontinue applying a laboratory number on any future bags. This is an example of a commitment to policy compliance followed by effective problem solving. Quality improvement activities have been undertaken in the Maternity Unit to ensure identification of babies is 100% compliant with Healthscope and National Standards.

Processes to transfer care

Close attention is given to identifying patients during all transfers, clinical handover and discharge processes. Compliance is monitored.

Processes to match patients and their care

PP guide the requirements around ensuring that patients receive their intended treatment, procedure or investigation. The surgical safety checklist (team time-out) is completed at the commencement of an OT procedure. Audit results indicate very high compliance rates with policy requirements, although compliance has been negatively impacted by the use of abbreviations in some cases. Sufficient time is also allocated to the instrument count which is conducted during each case. Time-out checking is also used in the palliative care unit before chemotherapy treatments.

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Good evidence exists of the presence of a robust set of policies and procedures to guide effective clinical handover. Ample staff education has taken place and an effective E-learning package is available to all clinical staff (ELMO) and it is clear that this learning package is well utilised.

The details of bedside changeover are adapted to the particular situation, such as transfer for investigations, discharge to another service, patient unconscious in Intensive Care Unit.

An extensive working party was put in place in 2013-14 and led to the development of clinical worksheets to assist with clinical handover and the ISOBAR tool to guide the details of the process, and to formalised clinical rounding.

Auditing and analysis of audits has provided data and the impetus to guide improvements and tweaking of the process to ensure more effective outcomes for the patients at the ward level. It is evident from review of data; analysis of this data and consideration by clinical review and quality committees that staff acceptance, patient satisfaction, and more efficient handovers are now in place.

Clinical handover processes

A range of clear and explicit clinical handover policies and detailed processes is now in place. There has been significant corporate support and input to the process. These policies are readily available at ward level to all nursing staff on the Corporate IT network (HINT). There is good evidence of regular audits with analysis of data giving reasonable evaluation and leading to more effective bedside changeover inclusive of effective patient involvement in the process and contribution to their own care plans.

Patient and carer involvement in clinical handover

Review of considerable data provided to the survey team; many discussions with groups of clinical staff and individual staff members, plus actual surveyor observation of a number of bedside changeover events was carried out. These events showed unequivocally that clinical handover has been developed to quite a significant level at this health service and that patients and members of the patients' families are being effectively involved with the process. Patient satisfaction studies have produced evidence indicating that patients appreciate and support bedside clinical changeover of staff and find the opportunity to ask questions and make input to their own care plans very satisfying.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Blood and blood product policies, procedures and protocols are consistent with National Blood Authority guidelines in regard to prescribing and administration of blood and blood products.

An enthusiastic Standard 7 working party oversees the organisation's systems to ensure that appropriate risk management is undertaken and to monitor actions taken to minimise risks. Appropriate reporting lines to the executive are in place. It is noted that the organisation transfuses between 360-400 units (mostly packed cells) into patients per year, mostly in elective circumstances although there is an awareness of the risks associated with some surgery performed at the hospital, and its obstetric service, which means that emergency blood administration is always a possibility.

The surveyors note the turnaround time of at least two hours from blood collection for group/cross match to blood availability which has necessitated the organisation putting steps in place to manage this unavoidable time delay. Practices include the availability of four units of O Negative blood on standby and the development of a Massive Transfusion Protocol. Practice sessions are held to support staff who may need to implement it at a moment's notice and, in extreme emergency, Queen Elizabeth 11 Hospital provides urgent blood products.

Haemovigilance activities are conducted, including reporting of adverse reactions, and are monitored by the Patient Care Review Committee.

A system is in place to ensure that adverse events are included in the incident management system where appropriate review takes place. Such events are minimal.

100% of nursing staff who administer blood undertake education in this regard including the BloodSafe e-learning module, which is mandated as an annual requirement.

Documenting patient information

A best possible blood history is taken as part of the admission process with information documented in the patient clinical record. Review of records against these parameters is undertaken and improvement in documentation has been steady.

Audit of adverse reaction documentation similarly shows slow but steady improvement.

A system is in place to appropriately report adverse events to executive, the pathology service provider, and to the product manufacturer as required although this is noted to be very rare.

Managing blood and blood product safety

Systems are in place to review risks associated with receipt, storage, collection and transport of blood and blood products and to ensure they are appropriately and safely administered.

Wastage is monitored, although surveyors note the difficulties associated with getting accurate wastage reports from the external provider. However a process is currently under development for timelier reporting and a system is in place to recycle unused O Negative blood stored on site for use elsewhere as it nears expiry date, thereby reducing wastage to minimal levels.

It is suggested that the organisation introduce a single unit policy to reduce unnecessary blood administration and further improve wastage as it is noted that there is currently no Hb (haemoglobin level) between first and second units in the Maternity Unit where it is a long time custom and practice to order two units routinely.

Communicating with patients and carers

Comprehensive information regarding blood and blood products is provided to both consumers and the clinical workforce. Information has been reviewed to make sure it is understood and meaningful for patients.

The majority of blood administered is to elective medical patients where the consent process is rigorous and contains all elements essential to informed consent. In the few instances where surgical patients may require the administration of blood or blood products, consent is currently procured as part of a general procedural consent process, which does not contain these elements. It is suggested that the organisation review surgical consent to ensure that patients are provided with sufficient information to give informed consent.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Preventing and managing pressure injuries at SPH is guided by Healthscope corporate policies and procedures (PP) and guidelines. A Pressure Injury Risk Assessment Tool is available to staff for screening and assessing patients. The outcomes of the assessment are used to plan patient care. At a local level, staff demonstrated strong commitment to the ongoing improvement around pressure area prevention. Compliance audits are undertaken quarterly, including documentation reviews. A recent audit of the quantity, quality and type of equipment available to staff resulted in a successful application for additional equipment.

Audit outcomes are compared to KPIs and reported via a monthly quality report provided to the Patient Care Review and Medical Advisory Committees. Strategies to maintain a high level of compliance with PP and guidelines are in place.

Preventing pressure injuries

100% of patients are risk assessed for pressure injury upon admission using a screening tool. The level of identified risk informs the care plan for each patient. SPH identifies the risk at admission and care is planned to include the equipment, education and monitoring to prevent pressure areas. Allied health staff work with nursing staff to prevent pressure injuries.

An excellent education program is in place for staff and patients. Staff of the Operating Theatre are currently reviewing the effectiveness of their pressure injury strategies. The documentation of patients who are being discharged or transferred provides information regarding pressure injury risk and management.

Managing pressure injuries

Wound management guidelines, PP and wound assessment tools are in place at SPH. Protocols for reporting pressure injuries are in place. Staff education is provided via a range of models such as orientation, ongoing face to face sessions, and shared learning across Healthscope.

Communicating with patients and carers

SPH provides education to patients and carers on how to prevent pressure injuries. Literature is available for patients to read in their rooms. Consumers have reviewed and approved the literature as being of a suitable level of understanding for patients and carers.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Action 8.1.2 Core

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

Surveyor Comment:

The data indicates a very low rate of low grade injury. Staff participate in the Pressure Injury Working Party. Staff have closely monitored the data and improve practices where needed. For example, staff identified an increase in older patients who are admitted from home with pressure injuries so reviewed their care, wound management and equipment to ensure they can continue to provide quality, safe care. Changes to selection and maintenance of equipment resulted from this review. All criteria for Met with Merit have been achieved

Surveyor's Recommendation:

No recommendation

Action 8.3.1 Core

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

Surveyor Comment:

The prevention and management of pressure injuries at Sunnybank commences with a risk assessment. There is almost total compliance with risk assessments upon admission and care being planned according to the risks identified. The hospital has a range of pressure relieving devices including the quality of the mattresses used on every bed. An audit of devices against an identified increasing demand because of the ageing patient cohort; and a review of the maintenance of the devices resulted in an improvement action plan which included a request to management for funding for more pressure preventing devices. The funding application was successful. All criteria for Met with Merit were achieved.

Surveyor's Recommendation:

No recommendation

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

Good governance arrangements are in place to support and encourage early escalation of clinical care, in the event that sudden deterioration occurs in the clinical status of a patient in hospital and undergoing routine observation. Any such events are reported via RiskMan software. These events are analysed, followed up clinically, and ultimately reported for further consideration by the Patient Care Review and Medical Advisory Committees. There is also regular review of Code Blue events as well as regular mortality review of deaths. Sudden clinical deterioration events are kept under close review by the hospital's Critical Care specialists, who also spend considerable effort in teaching about recognition of such deterioration and the great importance of early escalation to a higher level of clinical expertise.

All such incidents are reported through RiskMan and reviewed at the Critical Care Committee. Agreed track and trigger charts are in use and regular audit review to ascertain that escalation is not being delayed. At this stage there is well-established quarterly feedback to clinicians of KPI data and clinical learnings. The decision has now been made to put in place two-weekly review and feedback to involved clinicians on the basis that more immediacy will allow better retrieval of causative data and better opportunity to achieve improved clinical learnings for the involved staff as they should at that stage have better recall of the events.

Recognising clinical deterioration and escalating care

The use of standardised track and trigger charts based on those from the Quality Commission is well agreed and established. Many audit results are in evidence and as well as tracking events and escalation of care there has been careful review to ensure that established clinical algorisms "demand" referral to higher level care, either within 30 minutes or immediately, are being strictly adhered to as there is now more than ample evidence of the effectiveness of this approach in increasing patient safety and survival.

Responding to clinical deterioration

As indicated above these special observation charts with inbuilt instructions and colour coded sections are very effective in improving patient survival when the clinical algorisms for response are strictly adhered to. Analysis of results and early feedback to involved clinical staff have been critical in gaining their involvement and improving outcomes for the patients. This response to analysis of data from track and trigger chart events is well monitored at this health service and the awareness amongst staff of the importance of early and unfettered response is clearly gaining recognition. It is noted that reporting and effective use of a centralised Risk Register takes place.

It is noted that the general observation charts are well-designed and closely based on the Quality Commission's recommendations. The health service also now has specially modified general observation charts available for use by children and neonates.

Communicating with patients and carers

It was quite evident at survey from written evidence and discussions with staff and patients that patients and families are kept well involved in the development of care plans.

There is a clear policy and procedure to ask about Advance Care Plans. If available such plans are copied, laminated and placed at the front of the clinical record as well as being notated on the alert sheet. Advice is offered to patients who ask how to go about establishing an advance care plan for themselves.

Patients and families are advised how they can themselves initiate escalation of care in the event of very sudden collapse of the patient.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

This health service fully meets action 9.6.1.

At the time of survey (for all staff) basic life support theory was 100% compliant and practical exceeded 98%. A great many staff are advanced life support competent, including all ICU, nursery and labour ward staff and all employed medical staff, and a great many senior nursing staff. Some are advanced life support compliant for neonates.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

It is evident that Sunnybank Private Hospital (SPH) has appropriate systems in place for preventing falls and harm from falls. This standard is supported by the Corporate Falls Prevention Clinical Cluster Committee and the SPH Quality and Safety and Patient Care Review Committees for serious or sentinel events. Evidence-based policies, procedures, protocols and guidelines are in place with SPH adopting the corporate Falls Prevention and Management Policy.

A culture of safety, evaluation and improvement is evident throughout SPH in relation to quality improvement activities undertaken to prevent falls and minimise patient harm. Improvement projects include the introduction of the Patient Communication Board falls alert, proximate bed and chair alarms, red arm band alert system and GSC Grip Socks.

Falls prevention equipment is available to the clinical workforce to assist in reducing falls incidents of patients including proximate bed and chair alarms and associated pager system linked to the alarms and high-low beds. It is suggested that SPH evaluate accessibility and adequacy of prevention equipment and number of high-low beds required to meet patient needs.

Screening and assessing risks of falls and harm from falling

All patients admitted to SPH are screened for risk of falls and if risk is identified are then fully assessed using a validated tool - Falls Risk Assessment and Management Tool (FRAMT: HMR 7.9). The tool is completed at the time of admission and whenever there is a change in the patient's condition or ward/room change. Regular audits are conducted to provide clinical areas with reports against compliance with the minimum standards or criteria identified in the FRAMT. In the most recent audit undertaken in May 2016, 94%-100% (n=65) of patients had an initial risk screen completed within 24 hours.

Falls data is collected and submitted with the Healthscope Quality Key Performance Indicator Report. The total number of falls has been steadily decreasing over the past five years seeing a reduction from 75 (0.27%) in 2011 to 50 in 2015 (0.18%). Most recent ACHS indicator data (second half 2015) demonstrates that the SPH Inpatient Falls rate is 0.17% compared to the aggregate rate for peer agencies of 0.24%. Recommendations from the Falls Risk Assessment and Management Audit have guided annual action plans and are forming the basis for evaluation strategies.

SPH is involved in the Falls Prevention Clinical Cluster Committee to implement ways to assess risk and minimise harm for patients at risk of falling.

Preventing falls and harm from falling

The Falls Management Plan is incorporated into the screening and assessment tool (FRAMT-HMR:7.9). The FRAMT outlines interventions according to the level of risk identified. The FRAMT is audited through the documentation audit of the medical record.

Action has been taken to reduce falls and minimise harm for at-risk patients. This is evident from the introduction of the proximate bed and chair alarms and GSC Grip Socks. Audit results have identified the need for further education regarding the appropriate use of Grip Socks and falls education is now included as a regular in-service.

Additional initiatives introduced to prevent falls include the replacement of ceramic tiles at the front entrance with carpet tiles and worn carpet in the inpatient wards. Raising the awareness of falls risk and prevention has been undertaken through events such as April Falls Day.

Communicating with patients and carers

It is evident that SPH involves patients and carers in preventing falls and harm from falls. A range of education material is provided to patients throughout their hospital stay and across the continuum of care. The FRAMT interventions include the provision of Falls Prevention education information.

SPH utilises the corporate "Keeping a step ahead of falls: Falls prevention program" and the Queensland Government "How to Stay on Your Feet" checklist to support a consistent approach to consumer education and engagement in the prevention of falls. The material is readily available across the organisation and provides an effective means of raising awareness that falls are preventable.

The introduction of the SPH Patient Compendium includes information on falls prevention and management – "Keeping a step ahead of falls - Falls prevention program". The compendium is an excellent initiative and provides patients and carers with information regarding the prevention of falls and harm from falls. The evaluation of this resource will determine whether the information is meaningful and understood by patients and carers.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

STANDARD 11
SERVICE DELIVERY

Surveyor Summary

Information about services

Sunnybank Private Hospital (SPH) provides a range of information to patients and carers on admission to the service. Information brochures are on display within the hospital and are provided to all referring service providers. These include Patient Rights and Responsibilities, Healthscope Privacy Policy and The Right to Change (health insurance).

Patients and carers are able to attain accessible information at the bedside. A recent quality improvement project has seen the development and introduction of a Patient and Family Information bedside compendium. The compendium provides information regarding services available at SPH and clinical information to improve safety in hospital. The information brochure - 10 Tips for Safer Healthcare - is readily accessible throughout the hospital.

Access and admission to services

SPH has a well-developed system to support access and admission to the service. A range of initiatives has been introduced to promote access to SPH including the Bubbles and Bites Practice Manager event, Keeping it general – An evening with our general surgeons and Our Specialists Update. Admission processes have been reviewed and streamlined through the introduction of the Direct Admission Service 1300 number and the Central Bookings Procedure.

The Rehab/Medical Liaison Clinical Nurse has an established referral base and strong relationships are in place with GP practices and referring hospital Nurse Unit Managers and Discharge Planners. Inclusion and exclusion criteria are regularly reviewed to ensure equitable access to services is available to the local community. The Rehab/Medical Liaison Clinical Nurse is responsible for the rehabilitation and medical pre-admission screening process and necessary health fund checks, and works with the accepted patients in establishing their goals prior to admission.

Consumer / patient consent

It is evident that SPH has systems in place to obtain informed consent for medical and surgical treatment and for participation in the rehabilitation program. Specific consent processes for blood transfusion, informed financial consent, release of information and medical procedures are also in place. SPH undertakes clinical record audits to determine appropriateness and completion of consent processes on an annual basis.

Appropriate and effective care

Healthscope Corporate policies and procedures are in place and are based on relevant guidelines and evidence-based practice. All documents are available to clinical staff through the SPH intranet site. The Healthscope e-Credentialing Management System has been implemented and is linked to the WebPas and theatre module ensuring only credentialed VMOs provide services at the hospital.

Clinical Services meetings evaluate the use of evidence-based care and Casemix meetings are undertaken by a multidisciplinary team routinely throughout the week. Care planning is regulated and governed by the case conference process and is overseen by the senior medical specialist. Individual care plans are in place and formulated in consultation with the treating team. All care is planned with the patient and/or their carer on an individual basis and reviewed daily or as required.

It is evident that the rehabilitation program and care patients receive at SPH are effective as reflected by the Rehabilitation Medicine Indicators. Timely assessment of function is measured using the Functional Independence Measure (FIM) within 72 hours of admission and discharge. There is documented evidence that the multidisciplinary rehabilitation plan is established within an appropriate timeframe with 97.92% of patients having a care plan in place within seven days. Effective care is provided as demonstrated by the functional gain following the completed rehabilitation program (91.41%). This is below the peer group benchmark (97.85%) and is potentially related to FIM assessment on admission not reflecting function across a 24 hour period. Training of nursing staff in FIM assessment will enable this data to be captured and provides an opportunity for improvement.

Diverse needs and diverse backgrounds

SPH has a good understanding of the catchment demographic with low numbers of culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander people represented in the local population. The most prevalent cultural group includes people with Chinese origins.

Admission and pre-admission policies and procedures identify patients with special needs. Healthscope Corporate policies and procedures are in place to support the provision of culturally appropriate care. Information is available in Chinese, Italian and Greek and interpreter services are routinely used for non-English speaking patients. The menu has been recently reviewed to better meet the needs of the patient demographic with a variety of culturally appropriate meals now included, such as Congee Rice Porridge available on the breakfast menu for the Chinese population.

Pastoral services visit patients on a referral basis from the treating team or requests from patients and families. SPH has access to multi-faith pastoral care services.

Population health

Health promotion programs are in place and SPH has implemented strategies to promote better health and wellbeing. A Day Therapy Program has been developed and is provided on-site for outpatients. The program includes access to hydrotherapy which is delivered at a local pool.

SPH delivers a number of health promotion activities including the provision of flu vaccinations and community campaigns also feature regularly throughout the year, with events coordinated for Breast Cancer Awareness, April Falls Day, Purple Day (epilepsy) and Daffodil Day.

Information about services

Ratings

Action	Organisation	Surveyor
11.1.1	SM	SM
11.1.2	SM	SM
11.2.1	SM	SM
11.2.2	SM	SM

Access and admission to services

Ratings

Action	Organisation	Surveyor
11.3.1	SM	SM

Consumer / Patient Consent

Ratings

Action	Organisation	Surveyor
11.4.1	SM	SM
11.4.2	SM	SM

Appropriate and effective care

Ratings

Action	Organisation	Surveyor
11.5.1	SM	SM
11.5.2	SM	SM

Diverse needs and diverse backgrounds

Ratings

Action	Organisation	Surveyor
11.6.1	SM	SM
11.7.1	SM	SM
11.7.2	SM	SM

Population health

Ratings

Action	Organisation	Surveyor
11.8.1	SM	SM
11.9.1	SM	SM
11.9.2	SM	SM
11.10.1	SM	SM

STANDARD 12
PROVISION OF CARE

Surveyor Summary

Assessment and care planning

Healthscope provides policies, procedures and guidelines that are based on contemporary best practice and meet professional standards. All information is very accessible to staff. Assessment processes are used to identify patient care needs and guide the development of care plans. Allied health are on staff at SPH and participate in care planning. Planning for discharge is expected to commence upon admission. Audits are undertaken to monitor compliance and actions developed to make improvements where data indicates it is required. Strategies are in place to ensure the safe transfer of patients to other organisations. These transfer guidelines are evaluated to ensure compliance.

All assessments, care plans, patient histories and ongoing care documentation is audited and trended data available to the surveyors provided evidence of a high rate of compliance with Australian Standards, National Standards and Healthscope policies.

Regular patient satisfaction surveys are undertaken. Overall SPH receives very positive feedback. Any negative comments or suggestions are carefully considered by staff and changes made where possible.

Management of nutrition

As a component of patient-centred care, the nutritional status of the patient is assessed at admission. All patients who score poorly on an assessment are provided nutritional supplements and/or a special diet that meets their needs. Ward staff work closely with a nutritionist and the food services staff to meet the needs of patients. In the Oncology Ward, food is provided considering the special needs of the patient which may include having to change their chosen option with short notice. Mothers in the Obstetric Ward are provided access to snacks and a comprehensive menu. A special menu is available for bariatric patients.

A food safety audit is undertaken by the Queensland Government and achieved "compliant" status.

Ongoing care and discharge / transfer

Generic clinical pathways are used in Healthscope hospitals. There is ongoing analysis of the pathways. A new care pathway is being developed to guide end-of-life care. Weekly patient care reviews are carried out. A comprehensive range of assessments is undertaken as part of developing a patient-centred care plan for each patient. A discharge planner is available to support staff two days a week. Allied health staff contribute to the discharge planning processes. All patients receive a follow-up phone call after discharge. GPs are provided a digital copy of the nurse discharge plan within 48 hours of discharge. Maternity patients are visited post discharge by experienced midwives with pathways continuing to guide care.

Healthscope hospitals provide clinical indicator data to ACHS and this is used to compare care outcomes against similar-sized health facilities.

Education is provided to patients and carers to ensure that they are aware of any ongoing care needs and how to address the need or to access services.

End-of-life care

Policies, procedures and guidelines are in place to guide the care of the dying. A care pathway for end-of-life care is currently in the process of being developed. Nursing staff with palliative care qualifications work in the medical and surgical wards. All Advance Healthcare Directives are photocopied and added to the chart along with an alert to ensure staff are aware of it. The Patient Care Review Committee conducts reviews of all deaths and the Medical Advisory Committee considers all morbidity and mortality statistics and information.

Sunnybank Private Hospital has a range of patient education and care information in a variety of languages.

To date end-of-life care has been evaluated by the feedback received on cards from relatives of the patients. It is suggested that a more formal evaluation tool be developed and used on a periodic basis to improve care rather than rely on feedback from grateful relatives.

Assessment and care planning

Ratings

Action	Organisation	Surveyor
12.1.1	SM	SM
12.1.2	SM	SM
12.2.1	SM	SM
12.2.2	SM	SM
12.3.1	SM	SM
12.4.1	SM	SM

Management of nutrition

Ratings

Action	Organisation	Surveyor
12.5.1	SM	SM
12.5.2	SM	SM
12.6.1	SM	SM
12.6.2	SM	SM
12.6.3	SM	SM
12.7.1	SM	SM
12.7.2	SM	SM

Ongoing care and discharge / transfer

Ratings

Action	Organisation	Surveyor
12.8.1	SM	SM
12.8.2	SM	SM
12.8.3	SM	SM
12.9.1	SM	SM
12.10.1	SM	SM
12.10.2	SM	SM
12.10.3	SM	SM

End-of-life care

Ratings

Action	Organisation	Surveyor
12.11.1	SM	SM
12.11.2	SM	SM
12.12.1	SM	SM
12.12.2	SM	SM

STANDARD 13
WORKFORCE PLANNING AND MANAGEMENT

Surveyor Summary

Workforce planning

The evidence confirms that workforce planning is a high priority for this health service and an excellent collection of policies around this are in place and largely developed at the corporate office level. Workforce planning is a key plank in activities in place to support the current business and clinical activity plans.
There is ample evidence that the workforce management function and associated responsibilities are well identified with the General Manager having a key role around VMO appointments and the DON having overall responsibility for recruitment and management of all other staff. Job descriptions of managers establish their responsibilities for particular groups of staff and their role in supporting and reviewing staff members.

All aspects of staffing are covered in detail by Healthscope policies, including recruitment, staff development, education and support, as well as ethical and behavioural issues. There is particular responsibility on senior management and NUMs to monitor and maintain an appropriate skill mix consonant with the current patients under treatment. In addition to agreed regular staffing levels, plans are in place to deal with sudden unavailability of staff and peaks in clinical activity.

There is an awareness of the need to control the risk of fatigue amongst staff. The surveyors noted the current trial of some 12 hour shifts in the Intensive Care and Maternity Units. The survey team is pleased to note the intention of management to keep this trial under careful scrutiny for the risk of fatigue. Some possible issues around this trial were discussed with management at the time of survey.

Recruitment processes

There are appropriate policies and procedures in place to guide and control the various steps in recruitment of staff starting with review of the vacant position and ending with a formal letter of offer and acceptance. There is a stated aim of completing the recruitment process in two weeks after applications have been received. Claimed credentials and experience are checked as are two referees. Registration checks are undertaken for applicants and also for continuing staff. There are processes for regular updating of skills.

VMO appointments are well-controlled with a Healthscope online E-credentialing process and a local effective credentialing and scope of practice process well-embedded. Appointment letters for VMOs set out credentials and scope of practice. The Operating Theatre NUM has online access to this information in regard to surgeons.

There is a detailed set of by-laws that sets out in great detail all the required steps around VMO appointments. Credentialing is properly executed through a subcommittee of the Medical Advisory Committee. Initial VMO appointment is for 12 months and reappointments are either three or five years.

Discussions with VMOs, including the Chairman, made it quite clear that deviations from safe medical practice and reported unacceptable social behaviour by Visiting Medical Staff are well dealt with.

There is an active group of dedicated volunteers, which is under the control of a senior appointed member of staff. Proper selection and training are in place and volunteers receive good recognition by the health service.

Continuing employment and development

Detailed personnel records are kept for all staff. These records are kept under lock and key in the office of the Executive Assistant to the General Manager.

Very good attention is given to ensuring that all staff have current performance reviews. These reviews aim to discuss performance but also focus on training needs and career aspirations.

There are policies and procedures that deal with any complaints about staff attitudes or performance. Such complaints are rare but are taken very seriously and immediately dealt with.

Employee support and workplace relations

Workplace rights and responsibilities are well handled and there are no obvious outstanding staff grievances.

The survey team observed a very good level of staff interaction, cooperation and desire to deliver safe medical care.

The health service has introduced many initiatives to recognise and support staff. The initiatives include free staff parking, free breakfast food, Christmas lunch and monthly "thank you" lunches. There are also a number of regular staff recognition awards.

An effective employee assistance program is in place. This scheme is operated so that complete employee privacy is preserved.

Workforce planning

Ratings

Action	Organisation	Surveyor
13.1.1	SM	SM
13.1.2	SM	SM
13.2.1	SM	SM
13.3.1	SM	SM

Recruitment processes

Ratings

Action	Organisation	Surveyor
13.4.1	SM	SM
13.5.1	SM	SM
13.5.2	SM	SM
13.6.1	SM	SM

Continuing employment and development

Ratings

Action	Organisation	Surveyor
13.7.1	SM	SM
13.7.2	SM	SM
13.8.1	SM	SM
13.8.2	SM	SM
13.8.3	SM	SM
13.9.1	SM	SM
13.9.2	SM	SM

Employee support and workplace relations

Ratings

Action	Organisation	Surveyor
13.10.1	SM	SM
13.10.2	SM	SM
13.11.1	SM	SM
13.12.1	SM	SM
13.13.1	SM	SM

STANDARD 14
INFORMATION MANAGEMENT

Surveyor Summary

Health records management

It is evident that Sunnybank Private Hospital (SPH) has appropriate systems in place to manage health records. Evidence-based policies, procedures, protocols and guidelines that comply with relevant legislation are in place with SPH adopting the Healthscope Corporate Policies that apply to this criterion.

There is a well-developed system in place to manage health records within the constraints imposed by the physical environment. Records for a three-month period are held on site in a secure area and efficient systems are in place with TMIG to support timely and accurate retrieval and destruction of records. The effectiveness of the system is demonstrated by the fact that to date a medical record has not been lost.

SPH has a system in place to support the allocation and maintenance of healthcare identifiers. The WebPas allocates a unique identifier to all new patients. A WebPas unit record duplication report is run monthly and where duplicate records are found, action is taken to rectify this.

Clinical coding and classification are performed for all patients accessing services. Healthscope Corporate has established a Coding Cluster to support local Health Information Managers and Clinical Coders. SPH had experienced an extensive lag time for completion of clinical coding, however has resolved this over recent months with the backlog of coding now significantly reduced to acceptable levels.

SPH has processes in place by which the consumer/patient can gain access to their health record. The organisation adheres to the Healthscope Corporate policies relating to the release of health information. Consumers are advised how to access their health information when a request is made and this is further supported by the Patient Rights and Responsibilities brochure which is made available to consumers/patients. The responsibility for release of all health information sits with the General Manager who reviews all health information requests.

Corporate records management

It is evident that SPH has appropriate systems in place to manage corporate records created by the organisation. Policies, procedures and protocols that comply with relevant legislation are in place with SPH adopting the Healthscope Corporate policies that apply to this criterion. Clear flow charts and procedures are documented for the use of staff to ensure record keeping obligations are maintained.

Collection, use and storage of information

Policies and procedures are in place to guide information and data management collection systems. The collection and reporting of data are well managed with mandatory state-based data extraction reports submitted on time every month. The quality and integrity of data reported is high with a less than 2% error rate noted.

Health information data is reported to Healthscope Corporate and included in quarterly key performance and clinical indicator reports. Data is benchmarked and action plans developed for any areas outside the target parameters.

Information and communication technology

Healthscope Corporate ICT services have effective governance systems in place that are supported by a business continuity plan and include a risk management framework. A suite of policies and procedures is in place that addresses the management of ICT. Corporate ICT provides a support service and 24 hour response. SPH has a designated point of contact on site for the resolution of local issues, who is supported by the state-based ICT manager.

Health records management

Ratings

Action	Organisation	Surveyor
14.1.1	SM	SM
14.2.1	SM	SM
14.3.1	SM	SM
14.3.2	SM	SM
14.4.1	SM	SM

Corporate records management

Ratings

Action	Organisation	Surveyor
14.5.1	SM	SM

Collection, use and storage of information

Ratings

Action	Organisation	Surveyor
14.6.1	SM	SM
14.6.2	SM	SM
14.7.1	SM	SM
14.8.1	SM	SM

Information and communication technology

Ratings

Action	Organisation	Surveyor
14.9.1	SM	SM
14.9.2	SM	SM

STANDARD 15
CORPORATE SYSTEMS AND SAFETY

Surveyor Summary

Strategic and operational planning

A comprehensive strategic and operational planning process led by the corporate entity is in place. Documentation is prolific and includes the necessary components which link vision, mission and strategy to operations. While the General Manager is clearly immersed in this process, which includes oversight of a $40 million redevelopment which is currently underway, his regular attendance at the daily meeting relating to activity and bed management was evidence of ongoing commitment to operations at the local level. All activities are compliant with appropriate by-laws, articles of association and corporate requirements.

In the last eighteen months there has been almost a complete renewal of the executive team, including many Nurse Unit Managers (NUMs). This has enabled the organisation to re-energise and refresh, with plans for redevelopment, the introduction of new services and growth in many current services where it was previously considered difficult to achieve. A positive, enthusiastic organisational culture has emerged over time confirmed by surveyors at survey.

Systems and delegation practices

Extensive, formal governance processes, developed within an ethical framework are in place at the corporate level and include the necessary actions to meet the requirements of this criterion. A delegation policy is in place, and Sunnybank Private Hospital (SPH) is compliant in this regard. Rigorous financial systems of control are in place and reporting is thorough, timely and accurate.

Regular review of organisational structures and processes occurs to ensure that patient safety and quality is paramount.

The committee structure is comprehensive and meets organisational requirements for effective operational functioning although it was observed at survey that there is considerable variation in the recording of minutes throughout the organisation. It is therefore suggested that the organisation improve consistency in recording of minutes, including date/time and attendees as well as in the professionalism of content.

External service providers

External service providers are well managed, with appropriate governance systems in place. Documented service agreements are comprehensive and guide expectations, including dispute resolution; good controls are in place to monitor compliance with regulations and specified standards. Performance indicators are in place to measure and monitor performance.

As the hospital is undergoing renovation and a new building program, a corporate Liaison Officer has been appointed to facilitate relationships, including contract management, between the building company and the SPH executive.

Research governance

Negligible research is conducted at SPH but corporate systems guide processes in the event of requests for research and clinical trials being made. Such systems effectively govern research through regularly evaluated policy guidelines which are consistent with jurisdictional legislation, key NHMRC statements, codes of conduct and scientific review standards.

Safety management systems

A comprehensive suite of policies and procedures guides safety management practice. A system for workplace health and safety is in place; a recent improvement in this regard is the appointment of a new, appropriately qualified Workplace Health and Safety Officer (WHSO) who is already functioning in a well-supported environment which includes all relevant requirements for hazard identification, documented safe work practices, staff education, and an injury management program.

The surveyors note that the WHSO is about to undertake fire safety advisor training which will enhance the organisation’s already robust fire safety system.

An online dangerous goods and hazardous substances register with readily available Material Safety Data (MSD) sheets is in place and maintained by an external provider. All relevant staff are aware of, and know how to access, this system.

A private provider is responsible for the provision of medical imaging services. Regularly evaluated systems of control (as per the Service Agreement) are in place in regard to the radiation safety management system, including the training of a radiation safety officer and a laser safety training program undertaken by all staff working in this sphere. A radiation monitoring process for staff is in place and the organisation is compliant with all radiation safety requirements.

Buildings, plant and equipment

An effective system is in place in regard to the procurement, management, risk reduction and maintenance of buildings, plant, medical equipment and a range of other supplies and consumables, much of it corporate led.

The hospital presents as a very well-maintained property with current, temporary flexible systems in place to deal with the regularly changing requirements associated with the building program.

Active hazard monitoring takes place in this regard and in relation to ongoing operations of the hospital outside the building program.

Plant and equipment are installed and maintained in accordance with manufacturer specifications; most having service agreements with expert external providers in place to ensure this. A preventative maintenance and repair system is in place, and is both timely and reliable.

The surveyors note that several new plant and medical devices are included in the new building and that preparations are already underway to register these as assets for inclusion in the maintenance system.

Signage is clear and unambiguous and, on evaluation, meets the needs of its patient population, which is largely English speaking as a first language, or in the case of its Chinese populace, second generation Australian.

Disabled access is appropriate and facility design is compliant with legislative requirements.

Emergency and disaster management

The emergency and disaster management system is well-managed, inclusive of adequate training and testing. Evidence of high levels of compliance with mandatory training in this regard were observed. Emergencies have been clearly defined in both internal and external circumstances, and there is appropriate liaison between the organisation and a range of external emergency authorities and other hospitals in the local vicinity to deal with each contingency.

Appropriate planning is in place in regard to response, evacuation and relocation, with relevant signage and evacuation routes evident throughout the building.

Communication systems are robust; and mechanisms for business continuity are articulated and practised. Both areas have been tested in recent months with a number of Code Yellow (internal emergency) events being called in relation to both planned and accidental issues associated with the current building program. Good outcomes were noted in each case.

Appropriate documentary evidence was provided in regard to fire safety, including regular inspections by suitably qualified external personnel; at survey the very few numbers of recommendations had all been adequately addressed. Trained area wardens were in evidence.

Physical and personal security

Consideration for personal safety and security management is part of all service planning and a comprehensive range of policies, referenced to legislation, Australian standards, codes of practice and industry guidelines is in place to ensure that physical and personal security is optimised.

With the full participation of staff, risks in this regard are regularly assessed and systems of control in place include training in aggression management (which has its own specific plan), the use of duress alarms, frequent security company patrols overnight, and a review of external lighting.

Additional security measures include a system whereby entrance to the Maternity Unit is controlled at all times, and the placement of children in rooms located at the rear of wards without external access and close to the nurses' station for continuous observation.

Waste and environmental management

A waste management plan is in place and a range of recycling initiatives occurs to manage resource sustainability.

Appropriate systems operate in regard to the management of radioactive, hazardous and non-clinical waste.

Food waste audits have been conducted and have led to improvements in portion control and availability of popular foods.

The surveyors noted improvements to the aesthetic environment due to the creation of several therapeutic garden spaces, with more planned when building works are completed.

Strategic and operational planning

Ratings

Action	Organisation	Surveyor
15.1.1	SM	SM
15.1.2	SM	SM
15.1.3	SM	SM
15.2.1	SM	SM
15.2.2	SM	SM

Systems and delegation practices

Ratings

Action	Organisation	Surveyor
15.3.1	SM	SM
15.4.1	SM	SM
15.5.1	SM	SM
15.6.1	SM	SM
15.7.1	SM	SM
15.8.1	SM	SM

External Service Providers

Ratings

Action	Organisation	Surveyor
15.9.1	SM	SM
15.9.2	SM	SM

Research Governance

Ratings

Action	Organisation	Surveyor
15.10.1	SM	SM
15.10.2	SM	SM
15.11.1	SM	SM
15.11.2	SM	SM

Safety management systems

Ratings

Action	Organisation	Surveyor
15.12.1	SM	SM
15.13.1	SM	SM
15.13.2	SM	SM
15.13.3	SM	SM
15.14.1	SM	SM

Buildings, plant and equipment

Ratings

Action	Organisation	Surveyor
15.15.1	SM	SM
15.15.2	SM	SM
15.16.1	SM	SM
15.16.2	SM	SM
15.17.1	SM	SM

Emergency and disaster management

Ratings

Action	Organisation	Surveyor
15.18.1	SM	SM
15.19.1	SM	SM
15.20.1	SM	SM
15.20.2	SM	SM

Physical and personal security

Ratings

Action	Organisation	Surveyor
15.21.1	SM	SM
15.21.2	SM	SM
15.22.1	SM	SM
15.22.2	SM	SM
15.23.1	SM	SM

Waste and environmental management

Ratings

Action	Organisation	Surveyor
15.24.1	SM	SM
15.25.1	SM	SM
15.26.1	SM	SM

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM

1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

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

Incident and complaints management

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

1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM

4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

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

Continuity of medication management

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM

7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	SM
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	SM	SM
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	SM	SM
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	SM	SM
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	SM	SM

Documenting patient information

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

Managing blood and blood product safety

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

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	SM	SM
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	SM	SM

7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	SM	SM
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	SM	SM

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM

9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Service Delivery

Information about services

Action	Description	Organisation's self-rating	Surveyor Rating
11.1.1	There is evidence of evaluation and improvement of the quality of information provided to consumers / patients and the community about: • services provided by the organisation • access to support services, including advocacy.	SM	SM
11.1.2	The organisation’s processes for disseminating information on healthcare services are evaluated, and improved as required.	SM	SM
11.2.1	Healthcare providers within the organisation have information on relevant external services.	SM	SM
11.2.2	Relevant external service providers are provided with information on the health service and are informed of referral and entry processes.	SM	SM

Access and admission to services

Action	Description	Organisation's self-rating	Surveyor Rating
11.3.1	The organisation evaluates and improves its system for admission / entry and prioritisation of care, which includes: • documented processes for prioritisation • clear inclusion and/or exclusion criteria • management of waiting lists • minimisation of duplication • utilisation of information in referral documents from other service providers received on admission of the consumer / patient • management of access block.	SM	SM

Consumer / Patient Consent

Action	Description	Organisation's self-rating	Surveyor Rating
11.4.1	The organisation has implemented policies and procedures that address: • how consent is obtained • situations where implied consent is acceptable • situations where consent is unable to be given • when consent is not required • the limits of consent.	SM	SM
11.4.2	The consent system is evaluated, and improved as required.	SM	SM

Appropriate and effective care

Action	Description	Organisation's self-rating	Surveyor Rating
11.5.1	The organisation ensures appropriate and effective care through: • processes used to assess the appropriateness of care • an evaluation of the appropriateness of services provided • the involvement of clinicians, managers and consumers / patients in the evaluation of care and services.	SM	SM
11.5.2	Policy / guidelines are implemented that address the appropriateness of the setting in which care is provided including when consumers / patients are accommodated outside the specialty ward area.	SM	SM

Diverse needs and diverse backgrounds

Action	Description	Organisation's self-rating	Surveyor Rating
11.6.1	The organisation obtains demographic data to: • identify the diverse needs and diverse backgrounds of consumers / patients and carers • monitor and improve access to appropriate services • improve cultural competence, awareness and safety.	SM	SM
11.7.1	Policies and procedures that consider cultural and spiritual needs are implemented to ensure that care, services and food are provided in a manner that is appropriate to consumers / patients with diverse needs and from diverse backgrounds.	SM	SM
11.7.2	Mechanisms are implemented to improve the delivery of care to diverse populations through: • demonstrated partnerships with local and national organisations • providing staff with opportunities for training.	SM	SM

Population health

Action	Description	Organisation's self-rating	Surveyor Rating
11.8.1	Performance measures are developed, and quantitative and/or qualitative data collected, to evaluate the effectiveness / outcomes of health promotion programs and interventions implemented by the organisation.	SM	SM
11.9.1	The organisation identifies and responds to emerging health trends.	SM	SM

11.9.2	The organisation meets its legislative requirements for reporting on public health matters.	SM	SM
11.10.1	There is evidence of evaluation and improvement of strategies to promote better health and wellbeing, which include: • undertaking opportunistic health promotion / education strategies in partnership with consumers / patients, carers, staff and the community • providing education, training and resources for staff to support the development of evidence-based health promotion programs and interventions.	SM	SM

Provision of Care

Assessment and care planning

Action	Description	Organisation's self-rating	Surveyor Rating
12.1.1	Guidelines are available and accessible by staff to assess physical, spiritual, cultural, psychological and social, and health promotion needs.	SM	SM
12.1.2	Guidelines are available and accessible by staff on the specific health needs of self-identified Aboriginal and Torres Strait Islander consumers / patients.	SM	SM
12.2.1	The assessment process is evaluated to ensure that it includes: • timely assessment with consumer / patient and, where appropriate, carer participation • regular assessment of the consumer / patient need for pain / symptom management • provision of information to the consumer / patient on their health status.	SM	SM
12.2.2	Referral systems to other relevant service providers are evaluated, and improved as required.	SM	SM
12.3.1	Care planning and delivery are evaluated to ensure that they are: • effective • comprehensive • multidisciplinary • informed by assessment • documented in the health record • carried out with consumer / patient consent and, where appropriate, carer participation.	SM	SM
12.4.1	Planning for discharge / transfer of care is evaluated to ensure that it: • commences at assessment • is coordinated • consistently occurs • is multidisciplinary where appropriate • meets consumer / patient and carer needs.	SM	SM

Management of nutrition

Action	Description	Organisation's self-rating	Surveyor Rating
12.5.1	Policy / guidelines for: • delivery of nutritional care • prevention of malnutrition • assessment of need for assistance with meals are consistent with jurisdictional guidelines, adapted to local needs and implemented across the organisation.	SM	SM
12.5.2	The organisation's strategic and coordinated approach to delivering consumer / patient-centred nutritional care is evaluated, and improved as required.	SM	SM
12.6.1	Food, fluid and nutritional care form part of an intervention and clinical treatment plan.	SM	SM
12.6.2	Relevant healthcare providers use an approved nutrition risk screening tool to assess consumers / patients: • on admission • following a change of health status • weekly thereafter and referrals to nutrition-related services occur when needed.	SM	SM
12.6.3	The adequacy of consumer / patient nutrition is actively monitored and reported, and improvement is made to the nutritional care as required.	SM	SM
12.7.1	A multidisciplinary team oversees the organisation's nutrition management strategy to ensure that provision of food and fluid to consumers / patients is consistent with best-practice nutritional care.	SM	SM
12.7.2	Education programs for relevant staff about their roles and responsibilities for delivering best-practice nutritional care and preventing malnutrition are evaluated, and improved as required.	SM	SM

Ongoing care and discharge / transfer

Action	Description	Organisation's self-rating	Surveyor Rating
12.8.1	Discharge / transfer information is discussed with the consumer / patient and a written discharge summary and/or discharge instructions are provided.	SM	SM
12.8.2	Arrangements with other service providers and, where appropriate, the carer are made with consumer / patient consent and input, and confirmed prior to discharge / transfer of care.	SM	SM
12.8.3	Results of investigations follow the consumer / patient through the referral system.	SM	SM
12.9.1	Formalised follow up occurs for identified at-risk consumers / patients.	SM	SM
12.10.1	Formal processes for timely, multidisciplinary care coordination and/or case management for consumers / patients with ongoing care needs are evaluated, and improved as required.	SM	SM
12.10.2	Systems for screening and prioritising consumers / patients with ongoing care needs who regularly require readmission are evaluated, and improved as required.	SM	SM
12.10.3	Education is provided to consumers / patients requiring ongoing care and, where appropriate, to their carers.	SM	SM

End-of-life care

Action	Description	Organisation's self-rating	Surveyor Rating
12.11.1	Policy and procedures for the management of consumer / patient end-of-life care consistent with jurisdictional legislation, policy and common law are available and staff receive relevant education.	SM	SM
12.11.2	There is policy / guidelines for supporting staff, consumers / patients and carers involved in organ and tissue donation.	SM	SM
12.12.1	Access to and effectiveness of end-of-life care is evaluated, including through the use of clinical review committees.	SM	SM
12.12.2	A support system is used to assist staff, relatives, carers and consumers / patients affected by a death.	SM	SM

Workforce Planning and Management

Workforce planning

Action	Description	Organisation's self-rating	Surveyor Rating
13.1.1	Workforce management functions and responsibilities are clearly identified and documented.	SM	SM
13.1.2	The workforce policy, procedures, plan, goals and strategic direction are regularly reviewed, evaluated, and improved as required.	SM	SM
13.2.1	Contingency plans are developed to maintain safe, quality care if prescribed levels of skill mix of clinical and support staff are not available, and in order to manage workforce shortages.	SM	SM
13.3.1	The system for managing safe working hours and fatigue prevention is evaluated, and improved as required.	SM	SM

Recruitment processes

Action	Description	Organisation's self-rating	Surveyor Rating
13.4.1	The organisation-wide recruitment, selection and appointment systems are evaluated, and adapted to changing service needs where required.	SM	SM
13.5.1	Recruitment processes ensure adequate staff numbers and that the workforce has the necessary licences, registration, qualifications, skills and experience to perform its work.	SM	SM
13.5.2	The credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians, which is consistent with national standards and guidelines and with organisational policy, is evaluated, and improved as required.	SM	SM
13.6.1	The volunteer recruitment system supports an adequate number and mix of volunteers to complement the work undertaken by paid staff.	SM	SM

Continuing employment and development

Action	Description	Organisation's self-rating	Surveyor Rating
13.7.1	Accurate and complete personnel records, including training records, are maintained and kept confidential.	SM	SM
13.7.2	There is a system to document training for staff and volunteers which is identified as necessary by the organisation.	SM	SM

13.8.1	The performance assessment and development system includes: • review of position descriptions • review of competencies • monitoring of compliance with published codes of professional practice • assessment of learning and development needs • provision of adequate resources for learning and development • management of identified performance needs.	SM	SM
13.8.2	Ongoing monitoring and review of clinicians' performance is linked to the credentialling system.	SM	SM
13.8.3	The performance assessment and development system is evaluated through appropriate stakeholder consultation, and improved as required.	SM	SM
13.9.1	Processes are in place for managing a complaint or concern about a clinician, and there is evidence that they have been used.	SM	SM
13.9.2	Processes are in place for managing a complaint or concern about a member of staff, including contracted staff and volunteers, and there is evidence they have been used.	SM	SM

Employee support and workplace relations

Action	Description	Organisation's self-rating	Surveyor Rating
13.10.1	The workplace rights and responsibilities of management, staff and volunteers are clearly defined and communicated.	SM	SM
13.10.2	Managers take action on at-risk behaviour of staff and volunteers.	SM	SM
13.11.1	There is a consultative and transparent system to identify, manage and resolve workplace relations issues which is evaluated, and improved as required.	SM	SM
13.12.1	Strategies to: • motivate staff • acknowledge the value of staff • support flexible work practices are evaluated with staff participation, and improved as required.	SM	SM
13.13.1	Performance measures are used regularly to assess staff access to an employee assistance program and to evaluate the staff support services, and improvements are made as required.	SM	SM

Information Management

Health records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.1.1	Health records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • timely and accurate retrieval of records stored on or off site, or electronically • appropriate retention and destruction of records • training for relevant staff in health records management.	SM	SM

14.2.1	The system for the allocation and maintenance of the organisation-specific consumer / patient identifier, including a process for checking multiple identifiers, is evaluated, and improved as required.	SM	SM
14.3.1	Healthcare workers participate in the analysis of data including clinical classification information.	SM	SM
14.3.2	Clinical coding and reporting time frames that meet internal and external requirements are evaluated, and improved as required.	SM	SM
14.4.1	Consumers / patients are given advice / written guidelines on how to access their health information, and requests for access are met.	SM	SM

Corporate records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.5.1	Corporate records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • standardised record creation and tracking • appropriate retention and destruction of records • training for relevant staff in corporate records management.	SM	SM

Collection, use and storage of information

Action	Description	Organisation's self-rating	Surveyor Rating
14.6.1	Monitoring and analysis of clinical and non-clinical data and information occur to ensure: • accuracy, integrity and completeness • the timeliness of information and reports • that the needs of the organisation are met and improvements are made as required.	SM	SM
14.6.2	The information management system is evaluated to ensure that it includes: • identification of the needs of the organisation at all levels • compliance with professional and statutory requirements for collection, storage and use of data • the validation and protection of data and information • delineation of responsibility and accountability for action on data and information • adequate resourcing for the assessment, analysis and use of data • data storage and retrieval facilitated through effective classification and indexing • contribution to external databases and registers • training of relevant staff in information and data management.	SM	SM
14.7.1	The organisation uses data from external databases and registers for: • research • development • improvement activities	SM	SM

	• education • corporate and clinical decision making • improvement of care and services.		
14.8.1	Staff have access to contemporary reference and resource material.	SM	SM

Information and communication technology

Action	Description	Organisation's self-rating	Surveyor Rating
14.9.1	The ICT system is evaluated to ensure that it includes: • backup • security • redundancy • protection of privacy • virus detection • preventative maintenance and repair • disaster recovery / business continuity • risk and crisis management • monitoring of compliance with ICT policy and procedures.	SM	SM
14.9.2	Licences are purchased as required to ensure intellectual property rights and title to products are retained by product owners.	SM	SM

Corporate Systems And Safety

Strategic and operational planning

Action	Description	Organisation's self-rating	Surveyor Rating
15.1.1	The strategic plan that: • includes vision, mission and values • identifies priority areas for care, service delivery and facility development • considers the most efficient use of resources • includes analysis of community needs in the delivery of services • formally recognises relationships with relevant external organisations is regularly reviewed by the governing body.	SM	SM
15.1.2	Leaders and managers act to promote a positive organisational culture.	SM	SM
15.1.3	Operational plans developed to achieve the organisation's goals and objectives and day-to-day activities comply with appropriate by-laws, articles of association and/or policies and procedures.	SM	SM
15.2.1	Changes driven by the strategic plan are communicated to, and evaluated in consultation with, relevant stakeholders.	SM	SM
15.2.2	Change management strategies are implemented to achieve the objectives of the strategic and operational plans.	SM	SM

Systems and delegation practices

Action	Description	Organisation's self-rating	Surveyor Rating
15.3.1	The processes of governance and the performance of the governing body are evaluated to ensure that they include: • formal orientation and ongoing education for members of the governing body • defined terms of reference, composition and procedures for meetings of the governing body • communication of information about governing body activities and decisions with relevant stakeholders • defined duties and responsibilities and a role for strategy and monitoring.	SM	SM
15.4.1	Compliance with delegations is monitored and evaluated, and improved as required.	SM	SM
15.5.1	Organisational structures and processes are reviewed to ensure that quality services are delivered.	SM	SM
15.6.1	There is evidence of evaluation and improvement of the system to govern and document decision making with ethical implications, which includes: • a nominated consultative body • a process to receive, monitor and assess issues • review of outcomes.	SM	SM
15.7.1	Organisational committees: • have access to terms of reference, membership and procedures • record and confirm minutes and actions of meetings • implement decisions and are evaluated, and improved as required.	SM	SM
15.8.1	The organisation has sound financial management processes that: • are consistent with legislative and government requirements • include budget development and review • allocate resources based on service requirements identified in strategic and operational planning • ensure that useful, timely and accurate financial reports are provided to the governing body and relevant managers • include an external audit.	SM	SM

External Service Providers

Action	Description	Organisation's self-rating	Surveyor Rating
15.9.1	There is evidence of evaluation and improvement of systems to manage external service providers, which: • are governed by implemented policy and procedure • include documented service agreements • define dispute resolution mechanisms • monitor compliance of service providers with relevant regulatory requirements and specified standards • require evidence from service providers of internal evaluation of the services they provide • ensure that external service providers comply with organisational policy and procedures.	SM	SM
15.9.2	The organisation evaluates the performance of external service providers through agreed performance measures, including clinical	SM	SM

	outcomes and financial performance where appropriate, and improvements are made as required.		

Research Governance

Action	Description	Organisation's self-rating	Surveyor Rating
15.10.1	The system that: • determines what research requires ethical approval • oversees the ethical conduct of organisational research • monitors the completion of required reporting is evaluated, and improved as required.	SM	SM
15.10.2	Consumers and researchers work in partnership to make decisions about research priorities, policy and practices.	SM	SM
15.11.1	Systems are implemented to effectively govern research through policy / guidelines consistent with: • jurisdictional legislation • key NHMRC statements • codes of conduct • scientific review standards.	SM	SM
15.11.2	The governance of research through: • documented accountability and responsibility • establishing formal agreements with collaborating agencies • adequately resourcing the organisation's human research ethics committee (HREC), where applicable is evaluated, and improved as required.	SM	SM

Safety management systems

Action	Description	Organisation's self-rating	Surveyor Rating
15.12.1	Safety management systems include policies and procedures for: • work health and safety (WHS) • manual handling • injury management • management of dangerous goods and hazardous substances • staff education and training in WHS responsibilities.	SM	SM
15.13.1	The system for ensuring WHS includes: • identification of risks and hazards • documented safe work practices / safety rules for all relevant procedures and tasks in both clinical and non-clinical areas • staff consultation • staff education and provision of information • an injury management program • communication of risks to consumers / patients and visitors and is implemented, evaluated, and improved as required.	SM	SM
15.13.2	Staff with formal WHS responsibilities are appropriately trained.	SM	SM
15.13.3	A register of dangerous goods and hazardous substances is maintained and Material Safety Data Sheets (MSDSs) are available to staff.	SM	SM
15.14.1	There is evidence of evaluation and improvement of the radiation safety management plan, which: • is coordinated with external authorities • includes radiation equipment, a register for all radioactive	SM	SM

substances, and safe disposal of all radioactive waste
• ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA)
• keeps consumer / patient radiation to a minimum whilst maintaining good diagnostic quality
• includes a personal radiation monitoring system and any relevant area monitoring.

Buildings, plant and equipment

Action	Description	Organisation's self-rating	Surveyor Rating
15.15.1	The procurement, management, risk reduction and maintenance system includes: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables • workplace design.	SM	SM
15.15.2	Plant and other equipment are installed and operated in accordance with manufacturer specifications, and plant logs are maintained.	SM	SM
15.16.1	Incidents and hazards associated with: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables are documented and evaluated, and action is taken to reduce risk.	SM	SM
15.16.2	The safety and accessibility of buildings / workplaces, and the safe and consistent operation of plant and equipment, are evaluated, and improvements are made to reduce risk.	SM	SM
15.17.1	Access to the organisation is facilitated by: • clear internal and external signage • the use of relevant languages and multilingual / international symbols • the provision of disability access • facility design that meets legislative requirements and/or is based on recognised guidelines.	SM	SM

Emergency and disaster management

Action	Description	Organisation's self-rating	Surveyor Rating
15.18.1	There is evidence of evaluation and improvement of the emergency and disaster management systems, which include: • identification of potential internal and external emergencies and disasters • coordination with relevant external authorities • installation of an appropriate communication system • development of a response, evacuation and relocation plan • display of relevant signage and evacuation routes • planning for business continuity.	SM	SM
15.19.1	There is evidence of evaluation and improvement of staff training and competence in emergency procedures, which includes: • education at orientation • annual training in emergency, evacuation and relocation procedures • regularly conducted emergency practice / drill exercises • the appointment of an appropriately trained fire officer • access to first aid equipment and supplies, and training of relevant staff.	SM	SM
15.20.1	There is documented evidence that an authorised external provider undertakes a full fire report on the premises at least once within each EQuIPNational cycle and/or in accordance with jurisdictional legislation.	SM	SM
15.20.2	There is a documented plan to implement recommendations from the fire inspection.	SM	SM

Physical and personal security

Action	Description	Organisation's self-rating	Surveyor Rating
15.21.1	Service planning includes strategies for security management.	SM	SM
15.21.2	The organisation-wide system to identify and assess security risks, determine priorities and eliminate risks or implement controls is evaluated, and improved as required.	SM	SM
15.22.1	Staff are consulted in decision making that affects organisational and personal risk, and are informed of security risks and responsibilities.	SM	SM
15.22.2	Security management plans are coordinated with relevant external authorities.	SM	SM
15.23.1	The violence and aggression management plan is evaluated to ensure that it includes: • policies / procedures for the minimisation and management of violence and aggression • staff education and training • appropriate response to incidents.	SM	SM

Waste and environmental management

Action	Description	Organisation's self-rating	Surveyor Rating
15.24.1	The waste and environmental management system is evaluated to ensure that it includes: • development and implementation of policy • coordination with external authorities • staff instruction and provision of information on their responsibilities.	SM	SM
15.25.1	Controls are implemented to manage: • identification • handling • separation and segregation of clinical, radioactive ,hazardous and non-clinical waste, and the controls are evaluated, and improved as required.	SM	SM
15.26.1	The system to: • increase the efficiency of energy and water use • improve environmental sustainability • reduce carbon emissions is evaluated, and improved as required.	SM	SM

Recommendations from Current Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.10
Action: 3.10.1 The clinical workforce is trained in aseptic technique

Surveyor's Recommendation:

Ensure full compliance with aseptic technique training for relevant clinical staff.

Standard: Medication Safety
Item: 4.1
Action: 4.1.1 Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems

Surveyor's Recommendation:

Introduce a monitoring mechanism to ensure ongoing compliance with medication safety policy and ANZCA guidelines in the Operating Suite in regard to this practice.

Recommendations from Previous Survey

Not Applicable

Standards Rating Summary

Organisation: Sunnybank Private Hospital
Orgcode: 721758

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

Combined

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

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

Standards Rating Summary

Organisation: Sunnybank Private Hospital
Orgcode: 721758

Organisation - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**

Standards Rating Summary

Organisation: Sunnybank Private Hospital
Orgcode: 721758

Surveyor - NSQHSS V01

Core

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

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	18	2	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**207**	**2**	**209**

Developmental

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

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

Combined

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

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	22	2	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**254**	**2**	**256**	**Met**

Standards Rating Summary

Organisation: Sunnybank Private Hospital
Orgcode: 721758

Surveyor - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**