NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Prince of Wales Private Hospital

Randwick, NSW

Organisation Code: 12 00 01
Health Service Facility ID: 101011
Assessment Date: 30/07/2019 to 02/08/2019

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Introduction

Prince of Wales Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 30/07/2019 to 02/08/2019. The NS2 OWA required three assessors for a period of four days. Prince of Wales Private Hospital is a Private organisation. Prince of Wales Private Hospital was last assessed between 26-28/07/2016. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Prince of Wales Private Hospital	101011

General Discussion

Prince of Wales Private Hospital (PoWPH) is situated on the 5th – 7th floors of the Prince of Wales (POW) Campus Centre building operating within a lease agreement with South Eastern Sydney LHD and NSW Health. This very busy 168 bed private hospital has a predominately surgical and obstetric case mix. A very comprehensive pre-assessment account of systems and processes for quality and safety across all eight National Standards was provided. Assessors visited all clinical areas providing the opportunity to speak with staff and many patients and their families and met with PoWPH Executive including the recently appointed General Manager. Assessors also met with many visiting medical officers (VMOs) including members of the Medical Advisory Committee (MAC).

Assessors noted that staff were uniformly very proud of their organisation, valuing their high team spirit and the numerous opportunities for training and professional development and promotion within the organisation.

Standard 1
The Healthscope clinical governance framework informed the development of the PoWPH Clinical Governance Safety and Quality plan and the Quality and Risk Management Framework. The Healthscope Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan (RAP) has been included in the PoWPH Consumer Engagement Plan 2018-2021. Significant work has been undertaken to collaborate with the Aboriginal community to strengthen relationships and ensure that PoWPH is culturally welcoming.

The quality and safety management system are well defined and comprehensive.

The Healthscope integrated risk management system is well established in PoWPH. RiskMan is used to report incidents, near misses, complaints and sentinel events.

Since the implementation of the Board and Executive approved ‘Back to the Bedside’ project in April 2018 patient and consumer feedback has been enhanced through consistent use of the Acknowledge, Introduce, Duration, Explanation, Thank the person (AIDET) communication process, regular rounding of patient, clinical bedside handover involving patients, use of individual patient care boards.

Healthcare records are governed and managed consistently with appropriate policies and procedures and are easily accessible to all clinical staff at the point of care. As at 30 June 2019, 65% of all PoWPH episodes of care are uploaded onto My Health Record.

Observed systems and process indicate that the workforce has the right qualifications, skills and supervision to provide safe, high quality health care.

Site managers schedule and plan maintenance, testing and tagging, emergency generators, biomedical equipment and infrastructure site inspections to ensure compliance with Australian Standards and legislation including Work Health and Safety. Hospital signage has been enhanced following a consumer undertaken round. Assessors found the signage to be clear and appropriate.

Standard 2
Systems and processes are designed to ensure the patient and carers are at the centre of care, planning, improvements and evaluations. There is a Consumer Advisory Committee that provides input into the governance, leadership and management committees. Across PoWPH the assessors evidenced systems and processes in place to support patient and their carer involvement in care planning. Non-English speaking consumers are supported with the use of interpreters with information available in the appropriate language so that they can be more informed and make the best decisions regarding care. PoWPH ensures that the consumer information developed by the organisation meets the needs of the diverse population by having the brochures, posters, consent forms reviewed at the appropriate consumer advisory committees through either Healthscope or PoWPH.

Standard 3
Effective governance and safety and quality systems for the prevention and control of healthcare-associated infections and promotion of antimicrobial stewardship are well established. A multidisciplinary Infection Control Committee (ICC) meets bi-monthly and reports directly to the Management Committee. Infection control incidents, complaints and near misses, clinical audit outcomes and associated improvements are also reported and discussed at Consumer Advisory, Patient Care Review and Senior Clinical Managers Committees. Incidents of Hospital acquired infections is noted to be very low. Surveillance systems have been enhanced through the implementation of the online RL6 infection Control Solutions system. Continual improvement in compliance with the Hand Hygiene program demonstrates organisational commitment to prevention of healthcare associate infections with most recent facility wide rate of 91% compliance achieved.

An Antimicrobial Stewardship (AMS) Program is in place governed by the AMS Committee, a subcommittee of the Infection Control Committee. It also has formal links with the Pharmacy Committee, the governing committee of medication management.

Standard 4
The risks associated with medication management are understood and the related policies and procedures clearly articulate best practice of medication and related risk management. Robust processes are in place to maximise the opportunity for obtaining a Best Possible Medication History. All drugs are secured and stored consistent with relevant applicable legislation, Healthscope and PoWPH policy and procedures.

Standard 5
The Clinical Governance Framework clearly articulates the safety and quality systems, roles, responsibilities and processes to support comprehensive care across PoWPH. Policies and procedures reviewed by assessors, support the implementation of comprehensive care, the management of risks and facilitate workforce training to support implementation of comprehensive care across the organisation. All staff consulted identified specific improvements related to comprehensive care and were aware of and looking forward to the next potential improvement.

Screening tools have been standardised. Information on ATSI origin is collected on admission. Planning for discharge commences on admission. Transfer of care is monitored, and escalation processes are in place.

Standard 6

There is a comprehensive suite of policies, procedures and guidelines governing clinical communication. During the assessment multiple handovers and patient interactions were observed by the Assessors where patients and families, where appropriate, were involved in goal setting, shared decision making, care planning and assessment of progress. Compliance with policy, guidelines and procedures related to correct patient identification, procedure matching and approved identifiers, were evident. Significant improvements are evident with the appointment of a clinical documentation specialist to support the quality and standardisation of clinical documentation.

Standard 7

Relevant policies and procedures are in place and able to be accessed by all staff. Consent for blood and blood products is actively sought and obtained. Adverse events are reported consistent with national guidelines and data fed into ACHS clinical indicators. There have been no reported adverse outcomes relating to blood transfusions since 2014. PoWPH participates actively in the POW Campus wide haemovigilance activities which are also consistent with Healthscope requirements. The storage, distribution and tracing of blood and blood products is well governed and managed consistently with both Healthscope and POW Campus Blood Bank protocols.

Standard 8

There is a comprehensive set of policies and procedures at both Healthscope and PoWPH level governing recognising and responding to acute deterioration. There is a two phase response system: Code Blue requiring immediate attendance by the identified team and a Clinical Review call requiring attendance within 30 mins consistent with the track and trigger documentation process. PoWPH provides Consumer information empowering patients, carers or families to directly escalate care within the hospital's patient information directory and on the Patient Care Board at the end of each ward bed.

Summary of Results

Prince of Wales Private Hospital achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

Prince of Wales Private Hospital achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

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

Prince of Wales Private Hospital

Sites for Assessment

Sites for Assessment - Prince of Wales Private Hospital

Prince of Wales Private Hospital HSF ID:101011	
Address: Barker Street RANDWICK NSW 2031	Visited: Yes

Prince of Wales Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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

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

Not Applicable	

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

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

Assessment Team Summary:

The Healthscope clinical governance framework, endorsed by the Healthscope Board, has been adopted and used by the Prince of Wales Private Hospital (PoWPH) General Manager and the Senior Management team to develop, lead, support and monitor a positive culture of partnership in the delivery of safe and high quality of care for patients and consumers. The PoWPH Clinical Governance Safety and Quality Plan is aligned to the Healthscope Safety and Quality and Strategic Plans. The current PoWPH strategic plan was developed in December 2018 in consultation with consumer representatives and managers to reflect the Healthscope Strategic Plan, vision, values, strategic aims, purpose and priority areas for clinical outcomes and exceptional patient care. The Corporate Capital Expenditure Business Case template, used for all hospital equipment purchases and building projects, considers patient safety and quality issues.

The Healthscope ATSI Reconciliation Action Plan (RAP) has been included in the PoWPH Consumer Engagement Plan 2018-2021. Demographic data indicates 0.7% (n=282) of admissions identify as either Aboriginal and/or Torres Strait Islander. Nevertheless, significant work has been undertaken to collaborate with the Aboriginal community to strengthen relationships and ensure that PoWPH is culturally welcoming. Evidence provided included attending the La Perouse NGO Network meeting and ongoing communication with both Randwick Council and the POW Campus Aboriginal Liaison Officer and workforce having increased cultural awareness through training and celebrating Reconciliation Week.
Comprehensive reporting to the governing body occurs regarding safety and quality indicators (KPIs) and actions taken as a result of analysis of underperformance and critical incidents. These KPIs are also reported to five high level PoWPH Committee's including the Management, Senior Managers Clinical, Patient Care Review, Medical Advisory and Consumer Advisory Committees. The Committee structure has been reviewed and updated to reflect the revised Corporate Governance structure and recent

implementation of the hospitals ninth craft group. Committee and Craft Group Terms of Reference are included in the regular evaluation of Committee function and performance.

Staff were able to articulate their understanding of the clinical governance systems and their roles, responsibilities and accountabilities for safety and quality as defined in their position descriptions, by-laws, reporting lines and their experience with annual performance reviews and peer review processes.

Patient safety and quality systems

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

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

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

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

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

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

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

Action 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

Not Applicable	

Assessment Team Summary:

Quality and safety management system are well defined and comprehensive to comply with Healthscope requirements for regular monitoring of patient clinical outcomes including patient feedback through the Qualtrics patient experience process. In the last two years the addition of a Risk Adjusted Hospital Acquired Complication (HAC) rate means there are now 38 defined KPIs reported quarterly to Healthscope. The PoWPH Quality and Safety Plan outlines the comprehensive Healthscope organisation wide quality system focus for Monitoring, Reducing Risk and Continuous Improvement, designed to produce data that is timely and well-monitored and actioned as required to ensure areas of underperformance is addressed. These improvement actions form part of the organisations Quality Action Plan generated through the RiskMan tool. Participation in the Healthscope National Quality Management System through this quarterly KPI reporting, the well - established process for shared learnings and participation in relevant Healthscope Cluster Committees enhances the identification of potential continuous improvement. The recent implementation of the PoWPH Sentinel Learning Committee has further enhanced this process for clinical managers, clinical nurse specialists and nurse educator attendees. Department managers report relevant KPI data, patient feedback and incident data to their workforce, whilst staff forums, a quarterly staff newsletter and the recently introduced tele-information screens in staff lounge areas are used to display data outcomes. Consumer involvement in the review of safety and quality performance and systems is through the Consumer Advisory Committee and consumer membership on the Obstetric Committee and Patient Care Review Committee. The PoWPH MyHealthscope – Quality and Safety performance outcome data with relevant explanatory consumer information, is publicly available.

The Healthscope integrated risk management system which has a state-of-the-art customised version of RiskMan is well established through a comprehensive collection and classification of risk rated data and ability for managers and staff to analyse and treat or mitigate an identified risk. The risk register is generated through RiskMan and used to monitor and reduce the level of risk for the organisation. All risks are numbered and have a clearly identified owner to ensure tracking of risks is transparent. Staff were able to describe the risk management system and their role in reporting incidents, identified hazards and the potential key risks in their work areas. Whilst the assessors were able to track individual risks within the risk register it was difficult to link an identified risk with a corresponding quality improvement initiative in the quality action plan as the latter is only identified by the source rather than date commenced or reference number, consequently a suggestion has been made.

The healthcare record at PoWPH is hard copy. The only clinical electronic system currently in use is in maternity where care is monitored in real time with the K2 electronic system. This system is accessible remotely by the obstetricians. A copy of the K2 record is always filed within the hard copy record at the end of the episode of care. Pathology and imaging are available electronically for viewing with a hard copy always filed.

Healthcare records are governed and managed consistent with standards. Appropriate policies and procedures are well established, at both corporate and local levels, and are easily accessible to all staff via the intranet site. The healthcare record is easily accessible to all staff with clearly understood processes in place if access is required out of hours.

The relatively recent addition of the Clinical Documentation Specialist role has significantly improved the accuracy and completeness of the documentation supporting coding and the care and attention of the medical records staff in ensuring that the record structure and filing order are maintained. Routine audits verified whilst onsite support these statements. Improvements are ongoing with a recent example being the review of the management duplicate URs resulting in an action plan and ongoing monitoring. The healthcare records are stored securely in all areas with staff well aware of privacy requirements. A recent example of an improvement made by the medical record staff was the insistence of a third identifier in all requests for information from legal firms and other third parties.

The latest figures (30 June 2019) indicate that 65% of all PoWPH episodes of care are uploaded onto My Health Record. This is the result of active development of systems at both Healthscope Corporate and PoWPH levels. At admission consent is sought from all patients to upload records (event summary and nursing discharge summary) and the upload is completed at discharge. Random audits by the Clinical Documentation Specialist of these documents ensure the accuracy of the content of these documents. With respect to Advisory 18/11 PoWPH is well progressed and exceeding the time lines required in this advisory.

Suggestions for Improvement:

It is suggested that there is an opportunity to increase monitoring practice against relevant policy requirements through more frequent ad hoc observational audits.

There is an opportunity to enhance the processes for documenting quality action initiatives by dating each entry, using an identifier/reference number and where relevant recording the related RiskMan generated incident number to facilitate a timely integration between an identified risk and resulting quality improvement initiative.

Clinical performance and effectiveness

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

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

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

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

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

Assessment Team Summary:

Education for new employees and existing staff regarding safety and quality is thorough. The well-established and evaluated orientation and mandatory education programs is well received by managers and staff which attributes to the embedded culture of quality and safety observed during assessment. Examples of recent enhancements to the PoWPH training schedules include Awareness training in ATSI cultural safety; Cardiac Advanced Life Support training in collaboration with the co-located public hospital; point of care testing for the rotational thromboelastometry (ROTEM) training; Clinical Documentation Specialist training for clinical staff and Robotic training for theatre staff. This year PoWPH has also provided work opportunities for students and new graduates who identify as Aboriginal and live in the local community.

Healthscope policies define workforce performance review process which focus on governance compliance, professional goals, educational needs and compliance with mandatory training and competency assessment. The Management/Senior Clinical Manager Committees are responsible for overseeing appraisal compliance.

There are good systems and process in place to define, monitor and review scope of practice for all clinicians. The Medical Advisory Committee (MAC) acts as the credentialing authority for the all medical officers (VMO and CMO) in accordance with the Healthscope By-Laws for VMOs and Allied Health staff. VMO scope of practice is retained in the cGov Doctor eCredentialing System and is available to relevant PoWPH staff through the WebPAS. Both credentialing and scope of practice for VMOs is closely monitored and reported in the Healthscope quarterly KPIs with a target of 100% compliance. Nursing and Allied Health scope of practice and required registration is stated in position descriptions and monitored through medical record documentation of signature and role designation and through APHRA for registration.

Healthscope policy 2.32 New Interventional Procedures was used to establish the new Robotic Theatre in 2018 to ensure compliance with VMO credentialing, equipment selection, medical and staff training, environmental and redesign requirements.

Good processes are in place to maximise the opportunity for staff to understand and perform their roles and responsibilities for safety and quality. Assignment of safety and quality roles for responsibilities the workforce including locums and agency is through position descriptions, orientation, eLearning training packages, regular feedback and supervision as required. Supernumerary periods for new staff with access to preceptors is available as required.

The workforce including clinicians, have access to the intranet and the Healthscope librarian for clinical guidelines and standards including ACSQHC Clinical Care Standards that are relevant and current to the ACQSHC National Standards and the scope of clinical practice in PoWPH. Assessors Evidenced documentation of the implementation of the Acute Coronary Syndromes Clinical Standard, Acute Stroke Clinical Care Standard, Delirium Clinical Care Standard, Venous Thromboembolism Clinical Care Standard, and the End of Life Consensus Statement. The Colonoscopy Clinical Care Standard has been tabled and endorsed at the MAC (May 2019) and distributed to relevant surgeons, physicians and anaesthetists in line with their updated scope of practice. ACHS Clinical Indicators (5.1, 3.1 and 2.2) and the Colonoscopy Clinical Care Standard indicators are being used to monitor variation in practice and provide opportunity for clinician feedback. Consequently, the requirements of Advisory AS18/12 have been met.

Robust systems and processes monitor variation in practice through submitted data, benchmarking and outlier analysis through internal and external registries. Clinical indicator, HAC and audit data outcomes are tabled at the Patient Care Review, Management and MAC Committees as well as the relevant craft group Morbidity and Mortality forums.

Safe environment for the delivery of care

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope procurement guidelines ensure that facilities embarking on design or re-design projects are equipped with the required processes to maximise safety and quality of care. Site managers schedule and plan maintenance, testing and tagging, emergency generators, biomedical equipment and infrastructure site inspections to ensure compliance with Australian Standards and legislation including Work Health and Safety. All incidents and hazards are reported into RiskMan with seven controlled risk currently being managed on the risk register.

Potential high-risk patients with unpredictable behaviour have been identified through Shared Learning opportunities facilitated by Healthscope. A recent full review of potential mental health incidents in the Obstetric unit has identified the opportunity to enhance the current screening tools to include early identification in the ante natal period of at-risk mothers. Other strategies to ensure a calm and quiet environment have included providing rooms for both parents to co-share and having afternoon quiet time in the Obstetric Unit.

Workforce education and training is aligned with risk and safety management systems with a focus on manual handling, violence and aggression training. Code Black training has been added to the emergency procedures training. Staff duress buttons are now at all bedsides. The hospital is locked down at night.

Hospital signage has been enhanced following a consumer undertaken round. Assessors found the signage to be clear and appropriate. Toilets are clearly marked and have braille plate reference for the sight impaired.

Flexible visiting arrangements are prompted through the hospital website and apply to the Obstetric unit for fathers, parents of a child under 16 years old, parents, family or care of patient with cognitive impairment or receiving end-of-life care and as clinically appropriate.

Implementation of Healthscope Policy 1.03 Acknowledgement of Country includes acknowledging the Bidjigal and Gadigal Peoples of the Eora nation at orientation, at the commencement of the Consumer Advisory Committee and within the patient Information Directory and on the staff tele-information screens. Aboriginal Artwork is used throughout the hospital and the Aboriginal Atlas is displayed at the hospital entrance on Level 5.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

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

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

Assessment Team Summary:

The PoWPH clinical governance framework supports partnering with consumers in governance, delivery of care, review and the improvement systems, with a focus on engagement of both consumers and staff in the process design. The systems and processes are designed to ensure the patient and carers is at the centre of care, planning, improvements and evaluations. The Healthscope and PoWPH policies, governance documents, committee structure and strategic and participation plans all demonstrate partnering with consumers as a key element of the health service.

Consumer engagement has both strong safety and quality governance around how consumers are engaged in safety and quality of the health service. Consumer engagement is at all levels of the health service including at committee level in review of processes and outcomes. The committee minutes demonstrate involvement in decision making, monitoring of outcomes and quality improvements and in some instance's delegation of decisions. Consumers participated during the assessment; Consumer Consultants were proud of their involvement and described outcomes where their advice had been implemented. One Consumer Consultant described herself as feeling like "part of the team". The consumer needs and perspectives are assessed and considered at each contact point and are drivers for improvements across the organisation.

Consumer Consultants as part of the Consumer Advisory Committee are appropriately risk screened, trained, supported, monitored and committee participation evaluated. Data is collected about the experience of the consumer through feedback and complaints including patient opinion, patient stories, and consumer surveys, both internally and externally.

Suggestions for Improvement:

Consideration is given to recruitment of Consumer Consultants from diverse or multicultural backgrounds that may represent the community more closely.

Partnering with patients in their own care

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

Across PoWPH the assessors evidenced systems and processes in place that supported patients and their carers being involved in their care. This included information on health care rights being readily available in public areas and at the point of care. Informed consent and informed financial consent is evidence based, compliant with legislation and inclusive of processes for substitute decisions makers if a consumer does not have the capacity short term or long term in making decisions. These are well supported by policies and processes that are monitored and evaluated. Monitoring of these processes is through documentation audits communicated through the committee structure. Consumer Consultants have been involved ensuring access and appropriateness of this information through the patient information directory. Information is available in multiple languages.

The workforce is supported with education related to the requirements of consent. There is evidence-based processes in place to ensure patients and carers are well informed, to both identify capacity and support consumers in the decision-making processes and support carers and families with appropriate referral for support as required. These are monitored appropriately, and results are used to inform the improvement process.

PoWPH has demonstrated to assessors a significant commitment and improvement to the engagement and partnership of patients in their own care. The 'back to bedside' project has clearly placed consumers as the primary partner in all care planning. The staff education and training associated with this project has been supported by an organisation wide strategic plan, implementation plan, change management plan, tools and resources that demonstrates the commitment to the consumer as a partner and the teamwork required to ensure success. The outcome of this improvement program has clearly facilitated or escalated other improvement strategies across the patient care continuum through a clear vision, strong teamwork and strong consumer participation and clearly identified consumer goals of care.

Re Advisory AS18/10: The subjects of this advisory are Actions 2.4, PoWPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Health literacy

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

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

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

Assessment Team Summary:

PoWPH has demonstrated a commitment to communicate in ways that support effective partnerships with consumers. There are strong systems and processes to ensure that individuals have appropriate information they need, and that information is readily available across the health care environment. Considerable work has been demonstrated ensuring that appropriate information is available across the patient journey, as exampled by the pre-admission process improvements focused on every patient having the right information, reducing the duplication of information gathering and processes to improve or eliminate issues such as wait times. This is exampled by the Healthscope last days of life toolkit, advanced care planning information, screening tools and supporting patient information based on best possible evidence. PoWPH ensures that the consumer information developed by the organisation meets the needs of the diverse population by having the brochures, posters, consent forms reviewed at the appropriate consumer advisory committees through either Healthscope or PoWPH.

There are policies and procedures in place that support non-English speaking consumers with the use of interpreters with some information available in the appropriate language so that they can be more informed and make the best decisions regarding care. Some examples demonstrated included the use of 'My Care Boards', the relationship with local Jewish community, acknowledgement of ATSI community and culturally welcoming to all people. PoWPH has systems and processes to support cultural practices of the community including a process for the Aboriginal Liaison Officer from the co-located service to provide advocacy and support for identifying Aboriginal People accessing services. Aboriginal Cultural Awareness training was added to the mandatory training scheduled in the 2018/19 year and is monitored at manager level, reported through the relevant Governance Committee and through Healthscope national monitoring.

Partnering with consumers in organisational design and governance

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

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

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

At the PoWPH organisational level, consumer representatives are full members of key organisational governance committees in peak safety and quality committees. The consumer representatives on these committees are clearly supported through both Healthscope and PoWPH systems and processes to assist navigating and understanding their role, responsibilities and the data.

There is a Consumer Advisory Committee that provides input into the governance, leadership and management committees. Representatives from this committee are involved in working groups in redesign or are involved in health service redesign. Examples included development of the patient My Care Boards, staff orientation, training, education and the redesign of the clinical environment. Consumer engagement in the design and governance is both formal and informal. Informal methodology such as 'Morning Tea with the Director of Nursing', Qualtrics feedback on patient engagement which is monitored weekly, Consumer Consultant 'walk around' and purposeful patient rounding by staff, managers and the executive have significantly impacted on the improvements associated with consumer engagement. The assessors held the impression that PoWPH was both consumer and community focused and have clearly engaged both the consumers and staff in placing the consumer at the centre of care and use high level team work to achieve this.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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

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

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

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

Assessment Team Summary:

Effective governance and safety and quality systems for the prevention and control of healthcare-associated infections and promotion of antimicrobial stewardship are well established through a contracted service with Healthcare Infection Control Management Resources (HICMR). A regular e-based HICMR newsletter ensures managers and staff are well informed of contemporary infection prevention and control (IPC) issues and changes. The appointed part time Infection Control Coordinator works closely with the HICMR consultant to operationalise all infection IPC activities.

HICMR risk assessed health-associated infections and antimicrobial stewardship policies and procedures, are readily available to staff on the intranet. Additional Healthscope and local policies are available to cover specific areas in PoWPH not covered in other policies. Systems and processes for policy review and updating as required are appropriate. Access to e Therapeutic Guidelines is available for clinicians on all computers. Risks associated with healthcare associated infection and antimicrobial stewardship are regularly reviewed. Workforce training in IPC and antimicrobial stewardship is included within the Mandatory training matrix, with related competency assessments undertaken, recorded and appropriately reported.

A multidisciplinary Infection Control Committee (ICC) meets bi-monthly and reports directly to the Management Committee. Infection control incidents, complaints and near misses, clinical audit outcomes and associated improvements are also reported and discussed at Consumer Advisory, Patient Care Review and Senior Clinical Managers Committees. Hospital acquired infections and hand hygiene compliance are reported in the Healthscope quarterly KPI data and benchmarked against peer facilities. The PoWPH Infection Control Risk Management Plan is updated annually, overseen by the IFC and approved by Executive team. Quality improvement is ongoing with several initiatives for continuous improvement to prevent and control healthcare associated infections evident, evaluated regularly in line with this plan. PoWPH has a representative on the Healthscope WebEx infection control team that has recently superseded the Cluster Committee. This team reviews relevant incidents, HAC rates, ACHS Clinical Indicators, policies and best practice and contributes to organisation wide Healthscope Shared Learnings.

Patient involvement in their care commences on admission with their completion of an infectious screening questionnaire used to determine care planning and appropriate accommodation. Hand hygiene posters adjacent to hand hygiene dispensers in high traffic areas and clinical entry and egress points along with multiple patient information brochures outlining infection prevention and control strategies for

patients and families were evident. PoWPH website and the My Healthscope patient information is exemplary.

Surveillance systems have been enhanced through the implementation of the online RL6 infection Control Solutions system. Microbiology results are automatically feed into this system with alerts generated to the PoWPH infection control coordinator. Results are reported at the ICC and reviewed and discussed before being made available to all department managers. Surveillance data for ACHS Infection Control Clinical Indicators (CI) and Healthscope Infection Control KPIs and Antimicrobial usage are collated, trended and benchmarked.

Infection prevention and control systems

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

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

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

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

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

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

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

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

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

Assessment Team Summary:

Infection prevention and control is clearly a high priority for PoWPH. Guidelines for standard and transmission-based precautions, consistent with the 2019 Australian Guidelines for Prevention and Control of Infection in Healthcare, are available for all clinical and non-clinical staff as required. Regular transmission-based precaution compliance audits have been enhanced to include observational audits of patients requiring precautions and receiving care resulting in the introduction of Personal Protective Equipment (PPE) Caddies and sporicidal wipes to address identified observed issues. Another appropriate improvement was the initiative to replace all carpet in patient rooms with vinyl, in line with best practice. A WebPAS generated nursing discharge /transfer summary sent with all patients transferring to another healthcare facility or community nursing service includes the patient infectious status. A POW site Pandemic Plan is available on the PoWPH Public IT system.

Continual improvement in compliance with the Hand Hygiene program demonstrates organisational commitment to prevention of healthcare associate infections with most recent facility wide rate of 91% compliance achieved, well above the Australian National benchmark of 80% and Healthscope target of greater than 85%. It is pleasing to see that medical compliance has continued to increase with a current compliance rate of 77%, reflecting the increased awareness strategies applied in craft groups and MAC meetings.

Compliance with Healthscope Policy 8.38 Aseptic Technique training and competency assessment is impressive. Identified procedures requiring Aseptic Technique (AT) are clearly defined and used for competency assessment and AT observational audits of relevant clinical staff. VMOs are now included in the hospital wide AT audit and account for greater than 10% of the audit population. Education and audit results are reported to the ICC and Patient Care Review Committee.

Access to an expansive suite of Healthscope policies on Invasive Medical Devices that are consistent with the 2019 edition of Australian Guidelines for prevention and control of infection in healthcare is evident. All invasive devices and their use are documented in a database. Annual invasive device audit is a requirement of the Quality Plan. The last audit undertaken in late 2018 demonstrated 95% compliance.

The assessors were impressed with the cleanliness and maintenance of this very busy organisation that occupies levels 5 to 7 of the Prince of Wales Campus Centre building. Assessors noted a range of initiatives in place to ensure compliance with Australian Guidelines for prevention and control of infection in healthcare including education and training opportunities and clear work instructions to meet policy requirements. PoWPH environmental cleaning is part of the Infection Control Plan with quarterly audits scheduled to assess the effectiveness of the environmental program.

Cleaning products are appropriately managed and safety data sheets are readily available. The majority of cleaning is contracted to two external contractors. Both contractors are required to attend an internal weekly audit for self-appraisal and inspection. Supply of linen is contracted with regular meetings with the supply company to ensure with compliance with AS/NZS4146:2000. A maintenance schedule for annual testing of the Thermal Mixing Valve (TMV) and Legionella (CFU) by external contractors is managed by the Maintenance with results reported immediately to the Infection Control Coordinator and tabled at the ICC. As PoWPH shares the campus with POW Public Hospital, reports pertaining to collocated shared cooling tower are monitored by the POW Maintenance Manager and reported to the ICC.

A workforce immunisation program consistent with the current national guidelines and NSW Health is well established and enhanced through the requirements for all new staff to demonstrate compliance with vaccination requirements prior to employment. Compliance with flu vaccination this year was very positive with 100% of staff in all high-risk area being vaccinated.

Reprocessing of reusable medical devices

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

Assessment Team Summary:

The recent redesign and refurbishment of the CSSD Department is outstanding. Management and staff are congratulated on the work undertaken to redesign and commission this area to ensure compliance with AS/NZS4187:2014. Plans are in place to complete a design and refit of the Endoscopy suite in early 2020. Staff training and competency assessment is well established and compliant with AS/NZS4187:2014. A Management and Quality System (MAQS) scanning system is used to track the reusable surgical instrument from the point of patient use, cleaning/disinfection and sterilisation processing cycle. This system is regularly tested back to patient records.

Antimicrobial stewardship

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

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

Assessment Team Summary:

An Antimicrobial Stewardship (AMS) Program is in place governed by the AMS Committee, a subcommittee of the Infection Control Committee. It also has formal links with the Pharmacy Committee, the governing committee of medical management. There is a formal antimicrobial stewardship policy. Speaking with various staff and VMOs during the assessment clearly demonstrated that this policy and the active monitoring of the use of restricted antibiotics is known. Outliers have been identified (using the NAPS audit) with respect to surgical prophylaxis therapeutic guidelines and continuing discussions the relevant VMOs is ongoing. This is particularly relevant to Advisory 18/08. Evidence of work in this regard was gathered from discussions with staff and review of the relevant committee records including the Medical Advisory Committee. There was clear evidence of monitoring of restricted antibiotic use with the biweekly AMS ward round completed by the AMS Pharmacist and the Infection Control Coordinator. The assessor had the opportunity of sitting in on the part of such a round which is currently paper based. The process depends on the identification of all episodes of prescription of a restricted antibiotic with the round reviewing the documented indications and the microbiology results followed by recommendations and documentation of who the feedback was given to. This process is documented within the medical record on a bright yellow sticker.

Further improvements to this process are under consideration and executive has indicated support in principal for all restricted antibiotics to be dispensed through the pharmacy provider (currently restricted antibiotics can be supplied through the impressed and stores system) and the formal engagement of a consultant Infectious Diseases Physician to join the AMS team. The opportunity to meet with the identified Infectious Diseases Physician presented itself during assessment during which he confirmed that active discussions were underway, and he was looking forward to joining the team later this year.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

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

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

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

Assessment Team Summary:

Clinicians have ready access to comprehensive corporate and local medication management policies and procedures at PoWPH management and ward level. The risks associated with medication management are understood and the related policies and procedures clearly articulate best practice of medication management and related risk management. Routine training is undertaken at orientation and annually via the standard eLearning system with additional learning implemented when and if issues are identified. Various improvement strategies have successfully been implemented since last assessment including the implementation of the Pharmaceutical Benefits Scheme - Hospital Medication Chart in 2017 and the changed storage requirement for Hydromorphone thus insuring that it is not confused with morphine when dispensed. PoWPH participates in the Healthscope Annual Audit including that National Standard Medication Chart Audit. The results of these various audits are tabled at the Medication Safety Committee (if relevant), the Pharmacy Committee and then to the senior governance meetings of the hospital. Medication incidents and near misses are actively documented in RiskMan and monitored to ensure review is completed. All nursing staff are required to undertake the Medication Safety eLearning module at orientation as well as a drug calculation competency assessment followed by a Med-Safe annual completion.

Patients were found to be well educated with respect to medications. For example, in discussion with patients undergoing chemotherapy for various cancers (n=4 spoken with at assessment visit) all were able to indicate what drugs they had running, what the general outline of the treatment regime was as well as the experienced and potential side effects. The patients were complimentary of the information sharing from the staff and indicated that they were included in these discussions and had as much information as they currently wished to have. They also advised that the printed documentation provided to them (in multiple copies) at discharge had been most useful and they were able to provide copies to their GP and any other relevant carers.

Documentation of patient information

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

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

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

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

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Robust processes are in place to maximise the opportunity for obtaining a Best Possible Medication History. At pre-admission a medication history is completed by the nursing staff and repeated on admission as well as a Medication Risk Assessment. If the score of this assessment if four or more a referral is generated to the pharmacy such that a comprehensive Medication Management Plan verified from at least two sources can be completed. Audit of this process has demonstrated marked improvement with the 2018/19 audit showing an 86% compliance, a marked improvement from the 2016/17 audit of 31%.

There is a clinical pharmacy service available to all wards and patients within PoWPH so that medication reconciliation can be actively achieved at any time. In addition, the pharmacist visits the wards each day to ascertain if any new referrals have occurred from the nursing staff or VMOs. The latest audit figures demonstrate a high compliance rate of medication management plan reconciliation on transfer to another ward (100%) and 90% on discharge.

Medication allergy and adverse reaction history is sought at pre-admission and then again at admission. Whilst the details are documented within the WebPAS and the healthcare record on the Alert Sheet which appears as the first page of the record, the obvious external sign that there may be an issue is the red armband, which signifies an Alert (not specific to medication issues). If a new allergy or drug reaction is observed during admission this is documented by the VMO and all required notifications made including to TGA.

Continuity of medication management

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

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

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

Assessment Team Summary:

All appropriate policies and procedures are in place at either the corporate or local level (all of which apply to PoWPH) and all are readily available and accessible by all staff. There is a well-structured process for acquiring the medication history from each patient both prior to and at admission with a risk assessment being completed to ensure that those patients requiring a detailed medical management plan are identified. The clinical pharmacist completes the medication reconciliation.

At discharge patients are provided with a list of current medications identifying any changes which have occurred during the admission and detailed instructions relevant to each medication. This list is used as the basis of discharge counselling with respect to medications. Discussions with patients during the assessment indicated that these documents were considered highly and much appreciated.

Medication management processes

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

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

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

Assessment Team Summary:

All drugs are secured and stored consistent with relevant applicable legislation, Healthscope and POWPH policy and procedures. Controlled drugs were observed to be stored and accounted for and registers duly maintained consistent with legal requirements. Temperature sensitive medicines are appropriately stored with fridges part of the daily ward audit schedule as well as being centrally monitored. Expired medications are routinely collected monthly by the DON and pharmacist and then disposed of consistent with protocol.

POWPH used the APINCH "system" to clearly identify their high-risk medications and used tall man lettering for labelling storage drugs. The storage of these high-risk medications is audited annually with the latest compliance being 97%.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

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

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

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

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

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

Assessment Team Summary:

The PoWPH Clinical Governance Framework clearly articulates the safety and quality systems, roles, responsibilities and processes to support comprehensive care. There are clear evidenced based policies and procedures, mandatory and optional training options and elements of comprehensive care are identified on the risk register with appropriate controls, actions and monitoring activities at both the Healthscope and PoWPH. Policies and procedures reviewed by assessors, support the implementation of comprehensive care, the management of risks and facilitated associated training to support implementation of comprehensive care across the organisation. The review and monitoring processes associated with comprehensive care are at both local level by the managers and at Healthscope level coordinated through the quality team to ensure the quality improvement cycle and compliance. The quarterly clinical KPI submission of core indicators to Healthscope that are reviewed nationally provide opportunity to identify trends, craft group feedback and integrated monitoring, risk and improvement systems and processes.

There is clear leadership on quality improvement strategies to drive consumer engaged comprehensive care across PoWPH. This has clearly been facilitated by the foundational and strategic Healthscope 'Back to Bedside' work and the high-level teamwork skills developed across the PoWPH. Some recent examples included the interdisciplinary team assessment at pre-admission, the clear link between incident management, the implementation of the reflection tool flow chart and education and training. These comprehensive care improvement strategies have demonstrated evidence-based planning, leadership, governance processes, consumer participation, monitoring, reporting, evaluation and feedback to staff.

Examples of quality systems and process improvement projects related to comprehensive care include standardised screening tool implementation to facilitate consistent client outcome measures, the review of care plans to align shared decision making and consumer goals, the redevelopment of admission focused care plans, nutritional screening and the patient care boards designed to meet the comprehensive care needs of patients and carers.

There is evidence of interdisciplinary planning and redesign of systems to ensure comprehensive care is in place with ongoing improvements planned; through working group, senior executive and consumer feedback and participation where possible. All staff consulted identified specific improvements related to comprehensive care and were aware of and looking forward to the next potential improvement. The priority of patient goals of care was evidenced by the bedside handover and review, discussion with the patients and carers at the point of care which was clearly communicated, documented and monitored within the care plan. Involvement of individuals, families and carers was also evident; where interviewed they were able to describe how they are involved and informed in ensuring comprehensive care is planned and delivered.

Developing the comprehensive care plan

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

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

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

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

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Across PoWPH the Assessors identified evidence of a systemic approach to ensure that timely assessment, inclusive of integrated screening is undertaken at pre-admission, the point of contact, during care and planning for discharge. Standardised assessment is undertaken in all specialities, with a clear process for endorsement of policies, forms and procedures to maintain a standard approach. Assessment is inclusive of physiological, psychological and social issues. The comprehensive care plans capture the specific needs of individuals in accordance with the information attained in the initial and ongoing assessments. Assessments are inclusive of identified risk. The use of the pre-admission questionnaire and screening tool informs the comprehensive WebPAS to flag patients who have a complexity of needs e.g. diabetes, drug and alcohol, cognitive impairment, malnutrition, high risk medications to name a few; to ensure that when presenting, all staff are aware and able to support patients for all their presenting health needs. Care planning is in collaboration with the patient and where possible, family members/carers.

PoWPH has undertaken an extensive review of the types of assessments undertaken at point of entry and have included in assessment forms, cognitive functioning screening and risk factors. Documentation audits capture the use of risk screening tools and actions taken when risks are identified. Staff at all levels were able to describe the auditing processes and where performance may be an issue. Quality improvement strategies in each unit captured actions being taken and this information is included in team meetings, clinical huddles, and communicated through the committee structure.

Multidisciplinary assessment processes are in place across PoWPH; for example, a review of the process undertaken at the bedside during handover demonstrated referral to social work and further supports in preparation for a successful discharge inclusive of goals, shared decision making and planned reassessment. There was similar review of assessment throughout services, another one of note is the Theatre flow improvement project that significantly links improved screening and planning to improve consumer outcomes and experiences. The improved comprehensive screening and care planning related to optimisation of patients own red cell mass, haemoglobin and iron stores, identification of and managing patients at risk of bleeding and the implementation of ROTEM is both comprehensive and patient focused. The random interviewing of patients and carers across PoWPH throughout this assessment, confirmed that shared decision-making protocols are in place across all specialities.

PoWPH has a systematised process for implementing change in processes and communicating through a range of strategies. Staff at all levels and across sites were able to describe how they are informed of requirements to improve practice through reviewed processes. The Consumer Advisory Committee contributes to the review of screening and assessment tools and providing feedback. Point of Prevalence audits capture compliance and performance is communicated within units for staff, and across the committee structure.

Screening tools have been standardised and are inclusive of all requirements against these standards and the actions required. There is routine capture of identification across demographics and cultural requirements, of note, all staff collect information on ATSI origin. The assessment form also captures whether a person has an Advance Health Care Directive, in addition the service has adopted the Clinical Excellence Commission evidence based Healthscope preparing for end-of-life framework.

PoWPH has a sound process for auditing of documentation to confirm that screening and assessment occurs in a timely manner and there was evidence across specialities that managers and clinicians had reviewed their data and determined key issues to be addressed. Evidence included results from Point of Prevalence audits, random clinical file audits, inclusive of those undertaken during assessment by assessors. Staff had access to results, managers were aware of their responsibilities and improvement strategies were aligned to results. The assessment team could observe and found through interviews with managers, clinicians and consumers an enthusiasm to provide thorough assessments, work with patients and their families across multidisciplinary teams and specialities to best meet an individual's comprehensive health and social needs and an ability to work with community services to ensure continuum and the quality improvement activities to ensure safe and timely transfer and discharge processes were in place.

Planning for discharge commences on admission, with each person entering the service, where this is possible and is reviewed at each bedside handover and reviewed at critical times of care. Discharge plan is documented on the Patient Care Board in each patient room, and there is evidence that there is a shared care plan, that identifies who the patient would like involved in their care.

Across PoWPH there was evidence of internal and external partnerships and collaboration to ensure that the comprehensive needs of a person are met. There are also formal processes in place to meet with key stakeholders across health services to ensure smooth pathways for delivery of specialist care needs, meetings are in place with the other on site health care provides, for instance the shared intensive care site, the inter service blood management committee and mental health specialists work with the co-located tertiary services to best meet the health needs of the community with access to services as required. Transfer of care is monitored, and escalation processes are in place.

Re Advisory AS18/14: The subjects of this advisory are Actions 5.7 and 5.10. PoWPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Re Advisory AS18/15: The subject of this advisory is Action 5.13. PoWPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Re Advisory AS18/04: The subjects of this advisory is Action 5.8. PoWPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Delivering comprehensive care

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

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

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

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

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

PoWPH clearly demonstrates the partnership of patients, carers and the workforce in both the planning and delivery of comprehensive care. Staff are supported with education and training relevant to comprehensive assessment, have a strong focus on patient goals and the elements of person-centred care and a strong commitment to teamwork and the 'Back to Bedside' program. The strength of these combined improvements has enabled significantly improved patient outcomes as demonstrated in the clinical indicator program, PoWPH pathway compliance, the quality KPI reporting processes and consumer reporting and satisfaction. These strategies along with deliberate rounding, bedside handovers with patient involvement and improved documentation have influenced the ability to implement strategies to address risk of harm such as prevention of falls, pressure area prevention, nutrition and hydration optimisation, cognitive impairment assessment, delirium screen and safely manage aggression and violence.

Staff interviewed as part of the assessment were able to describe how they include individuals and their families in developing and reviewing an agreed care plan. Multidisciplinary reviews occur at ward level throughout a person's admission and the assessment team was able to observe these clinical scrums across several specialities where a review of the current care plan, presenting conditions, any changes in

presentations, identification of existing risks and feedback from a person and/or their families is included in such reviews.

A review of the clinical records also demonstrated that such reviews are documented in the person's file, individuals were able to describe how they are involved in their care. There is the ability to assess and work with a person to capture end of life and the person's preferred actions are recorded in the file. Staff across PoWPH have access to a Palliative Care service that enables them to be informed and supported to care for a person at end of life. Ongoing reviews during a person's end of life ensures that timely review occurs against the shared goals of care and in accordance with advance care plans. Significant improvement in the clinical documentation has been improved through education, training and evidence-based resources; the Documentation quality improvement project that has significantly improved the written communication by clinicians and reduced the risk of miscommunication between clinicians.

Minimising patient harm

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

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

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

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

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

Action 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

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

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

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

Assessment Team Summary:

PoWPH risk assessment and comprehensive screening as described is systematised with evidenced based processes, commenced at pre-admission wherever possible, on admission, is included in handovers, alerts are placed on the electronic system WebPAS, as well as in the medical record. Clinicians in all areas were able to describe the types of interventions that they have in place to address identified risk, as well as the systems of care in place to refer to appropriate health and social services to ensure comprehensive and continuum of care is in place.

PoWPH has in place sound initiatives and policies and procedures both local and Healthscope wide, based on the best available evidence, to manage pressure injury and to ensure that wound management is in accordance with best practice. Skin integrity review is undertaken on admission and a record is kept of any potential risk and/or red or broken areas.

There are several modes of patient information available for patients to access, including family that supports a person to minimise risk of a breakdown in skin, as well as knowledge of how best to reduce harm. Equipment and devices are readily available, and staff can access this in a timely manner. Audits are in place to capture screening and pressure injuries are reported as an incident, trended information is reported to staff to inform the improvement process.

Falls prevention, the minimisation of harm from falls and post fall management are all included in the policies and procedures within PoWPH. All documentation and tools are evidence based on the Clinical Excellence Commission, appropriate monitoring and reporting processes are in place with feedback to staff and targeted health literacy information available to patients and carers. Falls risk is noted on the Patient Care Board, in the care plan, discussed at bedside handover and notation of equipment required. Equipment is available on the ward and was observed to be readily available, in good condition and monitored. A recent improvement strategy introduced an authorisation for patient special for prevention of falls, eliminated the use of grip socks and the participation of the Healthscope Falls Community of Practice research project aimed at optimising screening, mitigation strategies, consumer and family engagement, and training requirements. In addition, a flagging system at the bedside ensured that all staff were aware of the risk of falls and the care plan outlined the agreed plan to prevent falls occurring. All falls have a medical follow up assessment, documentation and reassessment. Information is shared with the person and their families/carers, with pamphlets available to provide information on how best to reduce the risks of falls.

Hydration and nutrition form a part of the person's assessment on admission, for example, record a person's weight, note any loss or gain of weight and monitoring is incorporated into care plan. Food allergies, cultural and religious dietary requirements are documented in medical record, WebPAS, care plan, Patient Care Board, and meet the national catering and monitoring standards. Referral to a dietitian is available across PoWPH for a person who is screened at risk of malnutrition, with supplements available for those at risk. Observation charts include fluid balance and dietary intake as required. Improvements across PoWPH are noted as inclusion of BMI on the malnutrition risk screening, implementation of the Qualtrics feedback system and the electronic menu, protected meal times and alert monitoring system. Catering staff were observed to identify patient and meal prior to delivery of meal.

PoWPH has undertaken significant improvements in the identification of people with cognitive impairment, with screening for early recognition and undertaking clinical reviews to ensure prevention, where possible and treatment to prevent delirium using the evidence-based risk assessment tool. A clinical review was observed, where the medication regime for a person at risk of delirium and the safe use of medication to ensure that prescribing was done in accordance with the best available evidence was discussed. All clinicians interviewed across all specialities discussed the history taking that they would undertake inclusive of family where information about changes in behaviour, establishing normal level of functioning prior to admission.

Similarly, there are systems in place to identify those at risk of aggression and violence across the health system, with alerts available through the WebPAS. PoWPH has an appropriate escalation process for use in response to aggression, all episodes are appropriately reviewed. Education and training related to management of aggression and violence is a component of mandatory training including responding with the intent to diffuse and to contain, training is in place for key staff to ensure that the skills and capability in this response are available. All incidents are reviewed to capture learnings and a recent improvement is the inclusion of secret duress in the nurse call system.

PoWPH has developed very sound local and Healthscope systems focused on comprehensive care and harm minimisation, these are monitored through governance committees, working groups and at ward level to improve the level of risk assessment, clinical review and interventions available to a person when entering and during their health care. Discharge summaries include the risks that were identified, and the treatment provided. These systems are reviewed regularly at ward and unit level, across disciplines and in collaboration with the relevant speciality. There is a well-supported and monitored improvement process that clearly demonstrates consumer engagement.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

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

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

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

Assessment Team Summary:

There is a comprehensive suite of policies, procedures and guidelines governing clinical communication supported by Healthscope corporate and PoWPH with appropriate development, consumer consultation, review and approval process related to communication for safety, clinical handover, clinical documentation and transfer of care. Staff could demonstrate policy and procedure access at ward level. Communicating for safety is a key aspect of the 'Back to Bedside' project including the AIDET communication technique, patient rounding and the focus on always events for both clinical and non-clinical staff. The 'always events' are behaviours that have focused staff on person centred care; the AIDET communication, patient rounding, bedside handover, patient care boards and acts of kindness have provided staff with a clear framework to communicate safely.

Clinical incidents are documented in RiskMan and reviewed appropriately through managers and the governance committee structure. Staff have access to education and training and regular updates related to communicating for safety. These include documentation, communication and review processes for identified risks. These also address transitions in care, both between areas and external providers. There is clear policy direction regarding consumer identification at both transition of care and high-risk situations, reinforced by guidelines, procedures and training. Compliance is monitored with routine audits communicated to both managers and the governance committee.

During the assessment multiple handovers and patient interactions were observed by the Assessors where patients and families, where appropriate, were involved in goal setting, shared decision making, care planning and assessment of progress. The AIDET format guided communication. The Multidisciplinary team meetings (huddles) were observed to have a structured process to ensure comprehensive care and clear communication. Audits of handover documentation, care plans and bedside handover are regularly conducted and reported to the governing committee.

The continuous improvement process is demonstrated by the 'Back to Bedside' project and the implementation plan, associated tools, AIDET and audits. This project has been implemented and evaluated; staff and patient feedback has been positive and linked to improved outcomes measured in the Australian Commission on Safety and Quality in Health Care patient experience question set measured through Qualtics platform and available to all department managers in real time for analysis. One staff member described that "it's great for the team, "We are all on the same page, we all know what needs to be done to ensure patients get the right care at the right time, it gives us more time with the patient".

The consumer is actively engaged because much of the communication happens at the bedside with the patient and family. Literature is safety focused, available electronically though the patient information directory and in hard copy, is evidenced based, contemporary and available in multiple languages. This information is designed to assist consumers in understanding the assessment and health literacy related to admission, facilitates increased ability to participate in shared decision making and goal setting.

Correct identification and procedure matching

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

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

Assessment Team Summary:

PoWPH has clear guidance in both Healthscope and PoWPH policy, guidelines and procedures related to correct patient identification, procedure matching and approved identifiers, the processes are clearly articulated to the variety of settings. Assessors observed the use of three approved identifiers aligned to best practice guidelines during handover, medication management, the transition of care, at the commencement of therapy including procedures and interventions. Identity bands had the approved content and the red alert bands were used appropriately.

The WebPAS patient information system has been developed to include four patient identifiers, PoWPH has systems and processes to assist staff with the use of the patient identification system, these are evidence based and were observed to be used by both clinical and no- clinical staff. The maternity unit have appropriate systems and processes to ensure the baby is correctly identified with four identifiers including gender. With consent parents of baby provide a photo to display on the cot and partner will wear a band identifying link to baby. Staff were observed to use the four identifiers when discharging a baby from nursery to care of parents.

Compliance of policies are audited including correct patient, procedure, correct site, surgical safety checklist including observation audits contributing to the Healthscope KPI reporting and monitoring. Auditing results are communicated to clinicians, managers and through the governance committee structure and feedback provided to staff regarding the requirements.

Non-compliance events are reported as incidents through RiskMan, reviewed and communicated through the governance committee and monitored at organisational and national level. Learning from incidents are de-identified and shared and managed, as such including collation, review, trending, analysis and action on patterns of non-compliance. Incidents were risk rated and escalated appropriately.

The various transfer, communication, referral and other forms of documentation require suitable identification information, which was observed to be completed by the assessment team at admission, medication management, handover, transfer of care, team time out, interventions, storage and use of expressed breast milk and other procedures.

Communication at clinical handover

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

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

Assessment Team Summary:

PoWPH has clear guidance in both Healthscope and PoWPH policy, guidelines and procedures related to clinical handover, the process is clearly articulated to the variety of settings. Assessors observed the use of appropriate bedside handover, clinical huddle meetings and in the clinical documentation using the ISBAR / AIDET communication tools at the transition of care. Identity bands had the approved content and the red allergy bands were used appropriately inclusive of critical information. Compliance is audited, trended, benchmarked, monitored and reported to managers, staff and through the committee governance structure. Incidents are monitored, de-identified and used to inform improvements and shared learnings.

Multiple handover of care was observed during the assessment; these included patient identifications. The handovers were consistently patient goal focused, engaged consumers in planning and shared decision making.

While handover generally included sound patient identification systems and practices, one observed handover was impeded by a very small, cramped medical handover room. While that handover itself was professional and well done, the cramped space, lack of privacy and of the screen to the whole team potentially reduce its effectiveness and standard of person centred.

Communication of critical information

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

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

Assessment Team Summary:

Significant improvements have been at PoWPH with the appointment of a clinical documentation specialist to support the quality and standardisation of clinical documentation. The use of Patient Care Boards in the ward area that have been customised for each area inclusive of consumer engagement in design and information, patients are encouraged to write notes or questions on their boards to support involvement and communication with clinicians and shared decision making at the bedside.

PoWPH has implemented significant improvements in the interdisciplinary team work across PoWPH, a particular improvement in noted in the pre-admission area with the use of WebPAS and the comprehensive risk screening at admission, the structured information and communication processes. Great attention has been paid to communication at this early phase that has then had a flow on improvement at all points of care transition across the services as a result. The teamwork team focus and targeted 'Back to Bedside' project improvement outcomes are evident in the improved process of handover, the consumer participation, satisfaction and outcomes. These two interventions have contributed to a significant staff satisfaction, evidenced by length of employment, low staff turnover, staff comments to assessors and medical practitioner satisfaction with systems and processes. Several staff members mentioned the teamwork as something they are proud of as well as the standard of care they are supported to provide with clear leadership and career progression support by leadership.

Documentation of information

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

Assessment Team Summary:

The documentation system and processes are supported by sound policies, procedures and guidelines that are evidence based and contemporary albeit a hard copy record. The records reviewed contained critical information, alerts, and contemporaneous multidisciplinary documentation describing assessment, planning progress and outcomes. Changes in patient condition and risk are clearly documented with appropriate escalation systems, there is evidence of appropriate communication of critical information in the files reviewed. Processes for clinical assessment were well documented in the clinical record, and changes of the care plan were entered, this was observed on assessment.

There is a formal system for entering new alerts into the record, governed by policy, with auditing and compliance overseen by the committee governance structure. The Clinical documentation specialist appointed to assist in both the quality and standardisation of clinical documentation directly supports clinicians in improvement, many clinicians consulted noted this as a significant improvement leading to improved outcomes for patients. Staff are also engaged in real time file audits providing feedback and motivation for improvement and increased documentation knowledge.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

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

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

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

Assessment Team Summary:

All relevant policies and procedures are in place and able to be accessed by all staff. There is active engagement of the PoWPH with the POW Campus Blood Bank and Transfusion Committee thus ensuring consistency of practice across this vast complex campus. PoWPH has been an active contributor to the Critical Bleeding Protocol (previously known as the Massive Blood Loss Protocol) which now incorporates a ROTEM guided pathway. The option for ROTEM guided management of critical bleeding was first made available at PoWPH sometime during 2018 and is being actively incorporated into practice. As the ROTEM pathway requires a ten minutes delay to process the blood sample, a non-ROTEM pathway is still available and used either due to immediacy of the clinical situation or due to lack of familiarity with ROTEM by the managing VMO.

All instances of use of the Critical Bleeding Protocol are documented as an incident on RiskMan and subject to review at the Transfusion Committee. Training and competency assessment on ROTEM has been undertaken for relevant theatre and ICU staff.

Consent for blood and blood products is actively sought and obtained including a question asked on completion of every Consent for Medical and/or Surgical Treatment specifically asking, “Do you consent to a blood transfusion if needed”. This then facilitates more specific conversation and consent if required. The experience of staff is that patients actively engage in this process and specific examples were discussed where patients had specific wishes for example Jehovah’s Witness patients.

Prescribing and clinical use of blood and blood products

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

It was pleasing to note during assessment that a number of patients identified with low haemoglobin preoperatively or pre-delivery were being actively managed to maximise red blood cell mass. This process, initially managed from the VMO rooms, is also actively reviewed at the pre-admission interview and brought to attention if required. Patients with specific needs, such as those of the Jehovah Witness faith, are actively identified and engaged with to ensure an understanding of their specific needs. The identification and management of high-risk obstetric patients with placenta accrete was raised by various staff during assessment as an example of the active management and planning to minimise blood loss by the use of the hybrid theatre for placement of vascular stents prior to LSCS to be inflated after baby delivered and as hysterectomy is undertaken. When this was recently undertaken blood loss in this very high-risk situation was limited to three litres. ROTEM guided critical blood loss protocol was also in play. The most recent audit of transfusion documentation completed in June 2019 demonstrated improved performance since the previous audit October 2018.

Adverse events are reported consistent with national guidelines and data fed into ACHS clinical indicators. Having said that there have been no reported adverse outcomes relating to blood transfusions since 2014. PoWPH participated actively in the POW Campus wide haemovigilance activities which are also consistent with Healthscope requirements.

Managing the availability and safety of blood and blood products

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

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

Assessment Team Summary:

The storage, distribution and tracing of blood and blood products is well governed and managed consistent with both Healthscope and POW Campus Blood Bank protocols. Blood and blood products are readily available and managed tightly with tracking occurring via barcodes and BloodTrack. Staff are well versed is these processes. The cold chain is actively controlled with fridges (one in theatre and one in ICU) being centrally and locally monitored. Blood and blood products are readily available from the POW Campus Blood Bank with no identified issues with respect to shortages of any products. The relatively recent implementation of the Critical Bleeding Protocol with a ROTEM guided option has improved the specificity of the blood products in appropriate cases thus minimising wastage.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

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

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

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

Assessment Team Summary:

There is a comprehensive set of policies and procedures at both Healthscope and PoWPH level governing recognising and responding to acute deterioration. These link closely with and rely on the clinical governance framework thus ensuring that risks associated with this area are recognised and documented as required. As PoWPH is co-located on the Randwick Hospital Campus it has access to clinical services available on the campus but not specifically provided by PoWPH e.g. psychiatry, geriatrics, palliative care, the emergency department as well as ready access to VMO accredited with PoWPH who may work at one

of the other Randwick facilities e.g. neonatology. For the PoWPH staff regular mock code blue training sessions are held with debrief completed to ensure maximum learnings from the process.

PoWPH uses a two-phase response system: Code Blue requiring immediate attendance by the identified team and a Clinical Review call requiring attendance within 30 mins consistent with the score of the tract and trigger physiological sign documentation process. The response times for each of these categories are actively monitored and improvements made. Recently it has been observed that a number of patients in the recovery area meet code blue criteria and, whilst the anaesthetist may be nearby, it is now agreed practice that a call is made for the team to respond in order to provide whatever assistance is required.

Consumer information empowering patients, carers or families to directly escalate care is provided within the hospital's patient information directory and on the Patient Care Board. The Clinical Excellence Commission 'REACH' process has been implemented and is now clearly displayed on every Patient Care Board.

Detecting and recognising acute deterioration, and escalating care

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

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

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

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

Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Observations are routinely and clearly documented on a track and trigger chart. These charts are routine reviewed during clinical handover. Patients who are at increased risk have often been identified through the risk assessment processes that are commenced at pre-admission and reviewed at admission. This includes the cognitive impairment risk assessment tool. If delirium is detected active monitoring and management is implemented.

"Track and trigger" charting has facilitated active management when the patient's physiological or psychological signs fall in the "call zone". Variations to the trigger points are documented by the medical staff [either VMO or Career Medical Office (CMO)]. If the patient reaches any of the trigger points nursing staff are empowered to call either a Clinical Review call which requires attendance of the team within 30 minutes or a Code Blue which requires attendance immediately. As there is at least one CMO on site 24 hours per day seven days per week there is always a doctor available with this team. In addition, if at any time a nurse is concerned about a patient either the CSR or Code Blue process can be instigated. Whilst the Rapid Response Team is adult focused if there is a need for neonatologist or paediatrician there are clearly available phone numbers to be called which go immediately through to relevant people such that they arrive within minutes from other parts of the campus. During the assessment period a response to a code call to the special care nursery (which turned out to be in error) was observed with immediate impact of staff attending within 60 seconds, who then had to be turned away.

Recently work has been completed to ensure that staff are aware of stroke assessment using the FAST acronym (face, arms speech and time) which has been used at least once since implementation identifying a person in very early stages (with a dropping mouth) with a positive outcome after acute treatment after transfer to the public hospital.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

The PoWPH code blue team, all of whom have completed advanced life support certificates, are available 24 hours per day. The core team consists of a CMO, nurse manager, nursing staff from the cardiac ward and the intensive care unit and a wardsperson. Others supplement this as required for example an intensivist, a neonatologist or a paediatrician.

As PoWPH does not have a mental health service there is a particular need to ensure accurate screening of patients prior to admission to ensure that a comprehensive care plan is developed cognisant of any mental health issues and consistent with the patient's psychiatric care plan. If acute deterioration occurs this plan and the emergency clinical contacts will be included in their care. Similarly, if not prior history psychiatric care is available on the Randwick Campus and advice sought as required.

Given PoWPH's geographic location in the middle of the comprehensive Randwick Hospital Campus, accessing services for patients whose acute condition does not fall within the clinical services provided PoWPH is reasonably easy. VMO and PoWPH are able to contact colleagues at an appropriate facility or the patient can be transferred to the public emergency department on site.

Recommendation from Current Assessment

Nil

Rating Summary

Prince of Wales Private Hospital

Health Service Facility ID: 101011

Standard 1 - Clinical Governance

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

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

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

Documentation of patient information

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

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

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

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met
5.18	Met
5.19	Met
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Not Applicable

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Standard 1

Organisation: Prince of Wales Private Hospital

Action 1.19: The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

Recommendation NSQHSS Survey 0716.1.4.3:
The organisation take the necessary steps to ensure that the locum and agency workforce has the necessary information, training and orientation to fulfil their safety and quality roles and responsibilities.

Organisation Action:

Prince of Wales Private Hospital (PoWPH) was in receipt of the ACHS final report recommendations in December 2016, the NSQHSS 1 committee was reconvened to monitor and report actions and progress to the Management Committee with membership from Executive, management and staff.

The recommendations were reviewed and the following actions taken:

- 2016 Healthscope reviewed the contracts for agency/locum staff with nominated tier one and two contractors selected
- The NSQHSS 1 committee confirmed that the contracts are inclusive of the contractor's responsibility for the education of their staff in Cardio pulmonary resuscitation, fire training, manual handling and infection control
- An audit was conducted within the 2016-17 governance audit of agency staff's knowledge of safety, quality and incident management responsibilities with an overall rating of 80%. Finalising the 2017/18 agency audit was challenging due to low agency numbers. Four attempts were made between March and June 2018 during which one agency staff was identified and audited with overall rating sustained at 80%
- 2018/19 audit plan is to recruit After Hours Manager to increase agency audit sample numbers with the After-Hours Managers being provided training on the audit tool
- The PoWPH orientation program for locum/agency staff remains in place with the agency staff orientation induction checklist again reviewed in July 2018 and March 2019 and includes:

  Confirmation of registration and scope of practice

  Confirmation that education on NSQHSS received from Agency

  Education provided on clinical review system/ rapid response team

  Department and hospital orientation

  Emergency procedures

  Incident/ injury/ hazard reporting procedures

  Security and Code Black protocols

Additions 2019 (I response to consumer feedback); Back to Bedside 'Always Events' and A.I.D.E.T communication model have been added to the induction training.

Back to Bedside
Exceptional Care. Every Patient. Every Time.

Staff are to use the **AIDET** communication model whilst on duty.
Acknowledge
Introduce
Duration
Explanation
Thank the person

The big 5 **Always Events** – every time, every hour, every shift, every day, every week by staff are:

1. Clear communication - ISBAR/AIDET
2. Patient Rounding
3. Bedside handover – every change of shift
4. Patient care boards – update every shift
5. Acts of kindness.

Agency staff also receive a health and safety Information brochure inclusive of:

Work Health and Safety
Manual handling procedure
Waste and hazardous substances disposal

Code of Conduct

Medication Safety

Substance Abuse

Security

Work place Violence

Hazard Reporting

Accident and Injury Reporting

Smoke Free work place

- 2018/19 Proposed plan to extend an invitation to tier one tier two agency/locum for the NSQHS standard Version 2 education day on 10 July 2019.
- An audit was conducted in October 2018 of agency staff's knowledge of safety, quality and incident management responsibilities with an overall rating of 77%. Following the audit in December 2018 a letter from PoWPH Director of Nursing was sent to tier one and tier two agency reiterating the agency responsibilities for providing quality and safety education including National Safety and Quality Health Standards (NSQHS), basic life support, manual handling training, aseptic non-touch technique and medication calculation competencies.
- A re-audit was undertaken in May 2019 which demonstrated 90% overall rating an improvement of 13% from the previous audit.

Completion Due By: August 2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Significant work has been undertaken to address the intent of this recommendation including the requirement that agencies ensure their locum and agency staff are able to demonstrate competency in CPR, Fire Safety, Manual Handing and Infection Control and have current registration. System and processes in place include a sign on register and orientation brochure that has recently updated to include the 'always events' and AIDET communication tool associated with the Back to the Bedside project. Locum and agency staff have access to all relevant policies. Consequently, this recommendation is closed.

Standard 2

Organisation: Prince of Wales Private Hospital
Action 2.12: The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Recommendation NSQHSS Survey 0716.2.3.1:
When consumers and/or carers join the organisation in formal consumer roles, ensure that there is a training program to prepare them for and maintain their roles over time, in relation to governance, planning and safety and quality decision making.

Organisation Action:

Prince of Wales Private Hospital was in receipt of the ACHS final report recommendations in December 2016, this and the appointment of a new General Manager was the impetus to review the PoWPH Consumer Engagement Model including consumer education.

The NSQHSS 2 committee was reconvened to monitor and provide feedback to the Management Committee with membership from Executive, management and staff.

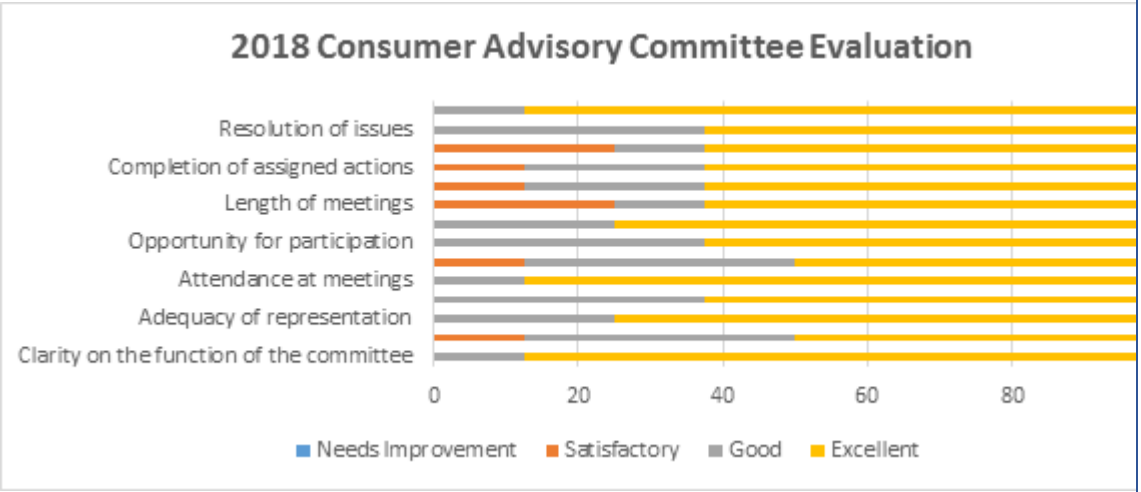
The Clinical Development Coordinator (CDC) undertook extensive research into models of consumer education in both the public and private healthcare sectors, with the results proving to be diverse such as those already established at PoWPH to education solely being provided by external providers.

With no clear model as guidance PoWPH decisions were:

- Continue the mentorship program for all PoWPH consumers
- Continue to utilise the Healthscope consumer orientation checklist and provide the PoWPH consumer induction manual. This ensures consumers are familiar with the health and safety mandatories, privacy and policy and procedure, with documents signed and a copy retained in the consumer file
- Continue with the consumer annual appraisal which includes identifying education needs of individual consumers with the addition in February 2017 of preferred modes of education to the tool

- Implement an eLearning program on 'On how to be a consumer at PoWPH' including governance, preparation for consumer responsibilities and reference tools. March 2017 the CDC developed the eLearning education with the:

- NSQHSS 2 committee members reviewing the first draft with revision of content and language
- eLearning draft two was then referred to the National Quality Manager and was reviewed by the Quality Team and the NSQHSS 2 cluster coordinator.
- Draft two was also referred to the PoWPH consumers and a Healthscope national consumer for review. This process has taken some time with the final very positive feedback received in July 2017.
- August/September 2017 the feedback was reviewed by the NSQHSS 2 committee, amendments made and application of the Healthscope consumer approved logo.
- Additional Consumer Consultant recruited March 2018 with eLearning distributed and completed with positive feedback gained at the inaugural Consumer Advisory Committee
- Healthscope has also established a consumer education programme with extensive consumer involvement which is being conducted in all States with NSW dates still to be advised. PoWPH extended an invitation to its consumer consultants and 3 Consumer Consultants attended the training in December 2018. Consumers evaluation of the program was fed back to Healthscope.
- 2018 June The Consumer Advisory Committee has been established with a Consumer Consultant elected as Chairman. This committee meets quarterly.



Completion Due By: August 2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

At the PoWPH organisational level, consumer representatives are full members of key organisational governance committees in peak safety and quality committees. The consumer representatives on these committees are clearly supported through both Healthscope and PoWPH systems and processes with

education, training and orientation to assist navigating and understanding their role, responsibilities and the data.

Standard 6

Organisation: Prince of Wales Private Hospital
Action 6.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes

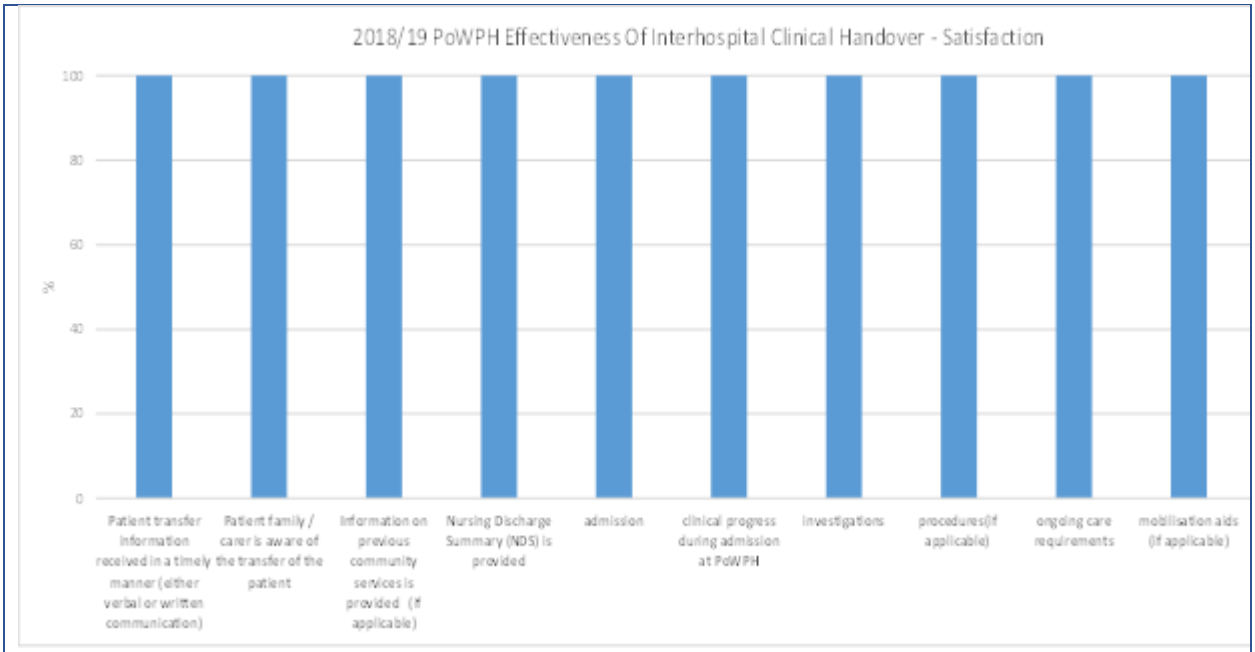
Recommendation NSQHSS Survey 0716.6.3.3:
Increase the effectiveness of clinical handover between external partner organisations (and other external agencies) by developing, implementing and monitoring a system for effective clinical handover in these circumstances.

Organisation Action:

Prince of Wales Private Hospital (PoWPH) was in receipt of the ACHS final report recommendations in December 2016, the PoWPH NSQHSS 6 committee was reconvened to provide monitor and provide feedback to the Management Committee with membership from management and staff.

The NSQHSS 6 committee reviewed this recommendation with the following actions:

- The Healthscope discharge planning audit was reviewed and is inclusive of patient centered discharge planning, documentation and community service requirement criteria however did not contain reference to external facility satisfaction. The 2016-17 audit outcome was 96.4%
- PoWPH has previously obtained feedback from external facilities but this had not been formalised therefore an audit tool was developed to gain quantitative data on external facility satisfaction on the transfer process as well as improvement suggestions
- The audit was conducted within the 2016-17 audit schedule with a 96.7% overall satisfaction rating
- Review of maternity service policy on the transfer of neonates to tertiary facilities in relation to notification within the nursing chain of command at both PoWPH and the external facility
- Effectiveness of clinical handover for Interfacility transfers has been included in the clinical audit schedule calendar with an overall satisfaction rating of 100% in 2018-19 an improvement from 97% in 2017-18.



Completion Due By: August 2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

There is a comprehensive suite of policies, procedures and guidelines governing clinical communication supported by Healthscope corporate and PoWPH with appropriate development, consumer consultation, review and approval process related to communication for safety, clinical handover, clinical documentation and transfer of care. Staff could demonstrate policy and procedure access at ward level. Much work has been done to both improve the quality and consistency of communication with external partners, discharge summaries were reviewed and support effective transfer of care. This improvement has been audited and will continue to improve with the documentation specialist role. Communicating for safety is a key aspect of the 'back to bedside' project including the AIDET communication technique, patient rounding and the focus on always events for both clinical and non-clinical staff. The 'always events' are behaviours that have focused staff on person centered care; the AIDET communication, patient rounding, bedside handover, patient care boards and acts of kindness have provided staff with a clear framework to communicate safely.

Standard 7

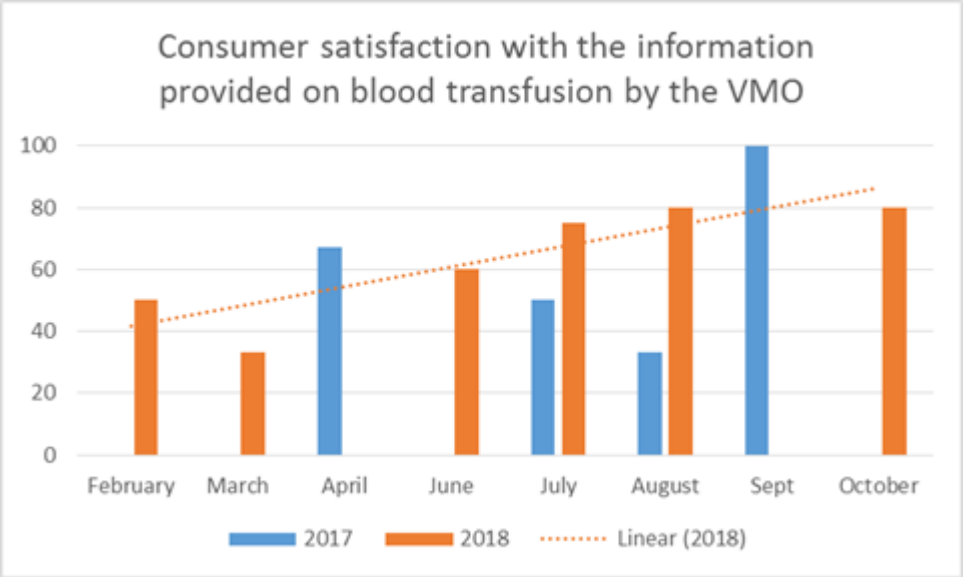
Organisation: Prince of Wales Private Hospital
Action 7.3: Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Recommendation NSQHSS Survey 0716.7.11.1:
Develop an audit schedule to identify whether or not informed consent is being obtained in regard to transfusion of blood and blood products and take steps, if required, to improve outcomes.

Organisation Action:

Prince of Wales Private Hospital (PoWPH) was in receipt of the ACHS final report recommendations in December 2016, the PoWPH NSQHSS 7 committee was reconvened reporting to the Management Committee with membership sourced from the management team and staff. The NSQHSS 7 committee reviewed this recommendation with the following actions:

- The PoWPH consent form has been made obsolete ensuring national (generic) tools are being utilised
- This Healthscope consent form (within the booking package) has no prompts for the VMO on the risks of blood transfusion, this has been relayed to the transfusion cluster for consideration
- The audit outcomes were presented at the July 2017 Patient Care Review Committee with the VMO Chairman indicating the indication for transfusion is discussed at the time of consent however was uncertain about risk/benefits. The audit outcomes were referred to the August 2017 Medical Advisory Committee (MAC) for discussion and suggested action.
- The PoWPH consumer was engaged to discuss with patients during consumer rounds with 66% of patients having received information on the risks and benefits of transfusion, it was also noted by the consumer that patients often were unable to recollect.
- PoWPH continues to provide blood transfusion information to all patients in the pre-dmission clinic who have a group & hold taken
- The Healthscope HMR 10.8 prescription and blood management tool includes documentation of confirmation that information has been provided at the time of consent
- The NSQHSS 7 team will await feedback from the MAC for additional suggested actions to facilitate compliance
- The August 2017 audit on consent to blood transfusion documented in the medical record was 96% compliant.
- March 2018 PoWPH sourced patient information to facilitate VMO compliance in providing informed consent at the time of consultation. Information was sourced from NSW CEC and the Victorian Government red cross service which were submitted to the August 2018 Medical Advisory Committee with the Victorian Government 'Blood Transfusion, Have all your questions been answered' selected as the most appropriate information. This has subsequently been distributed to the admitting VMO's
- PoWPH also engaged a Consumer Consultant to audit patient satisfaction with the information provided during the monthly consumer ward round, this has shown an improvement.



Hospital-Wide Version 12

ACHS Organisation Code: 120001 **Second Half 2018** **Australasia** **All Categories**

Total number of organisations for the selected category submitting data for this set for Second Half 2018: 393

CI No	Indicator Number/Description	Your Numerator	Your Denominator	Your Rate	99% Confidence Interval for Your Rate	Your Expected Number of Events	Number of Orgs Submitting Data 2H2018	Aggregate Rate for These Organisations 2H2018	Outlier	Graph
6.2	Transfusion episodes where informed patient consent was not documented (L)	1	234	0.427%	(0.000-1.523)	3	96	1.163%		Confidence Interval, Your Rate, Aggregate Rate; 0.000 0.305 0.609 0.914 1.218 1.523

2019

Compliance to blood transfusion consent and provision of patient information is now included in the VMO Induction and the Preadmission Clinic gives this to those patients under-going a ‘group and hold’ pathology.

Completion Due By: August 2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

An audit schedule has been developed and evidence was available at assessment that at least two audits have been completed and appropriate actions taken.