NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Sunnybank Private Hospital

SUNNYBANK, QLD

Organisation Code: 721758
Health Service Facility ID: 101177
Assessment Date: 15-17 June 2021

Accreditation Cycle: 1

Disclaimer: The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the ongoing safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.
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Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Sunnybank Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 15/06/2021 to 17/06/2021. The NS2 OWA required three assessors for a period of three days. Sunnybank Private Hospital is a Private health service. Sunnybank Private Hospital was last assessed at EQuIPNational Periodic Review between 19/09/2018 and 20/09/2018.

Sunnybank Private Hospital (SPH) underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 15 -17 June 2021. The NS2 OWA required three assessors for a period of three days. SPH is a 122-bed hospital providing surgical, medical and maternity services. The three highest DRGs are colonoscopy (same day), dental extractions and restoration and other gastroscopy for non-major digestive disease (same day).

Introduction
SPH is one of the 42 hospitals Australia wide managed by Healthscope. There is a corporate Board for Healthscope responsible for strategic governance and leadership and an SPH Executive Committee responsible for operational governance, leadership and management.

Standard 1

There is a sound Clinical Governance Framework (CGF) at Sunnybank Private Hospital (SPH) which focusses on delivering safe and effective patient-centred care. The CGF is very new, well developed and is focused on delivering safe and effective patient centred care within a collaborative approach with patients, people, and partners.

The CGF includes reporting against a range of Key Performance Indicators. There are effective communication systems and a committee structure that monitors and reports information to the Executive Committee and the Healthscope Board. The Values of Healthscope are well embedded in SPH staff and all levels of the hospital.

The OneHealthscope 2025 strategy was established through a process of consultation and documents objectives and a range of strategies to achieve the overall goal of an integrated health care business by 2025.

There is a positive culture for quality improvement within SPH and all staff are committed to patient-centred care. Of special note was the very positive feedback from patients interviewed or comments in the June 2021 patient experience survey.

There is an effective Risk Management Framework supported by appropriate policies/procedures that ensures staff have very clear information about safety and risks associated with their patients. The Medical Advisory Committee is the governance committee dealing with clinical incidents, sentinel events, and outcomes from clinical audits.

Feedback to assessors from patients interviewed or from a recent patient experience survey confirmed that there is a good level of communication between patients and staff at all levels.

Comments such as: my views and concerns were listened to; and I felt cared for-confirm the communication process.

Assessors were impressed with the establishment of four clinical Craft Groups and the range of issues reviewed and discussed. The inclusion of a Consultant Consumer as a committee member of each group demonstrates the high level of acceptance by clinicians of the value of having a consumer's opinion on matters discussed.

Staff Training is professionally managed by two qualified Educators and there appears to be a happy appetite by all staff and VMOs for continuing professional development.

Standard 2

There is a strong and genuine commitment to consumer engagement within SPH as documented in the Consumer Partnership Plan 2020-2023 which sets out practical strategies for partnering with their consumers in order to improve patient experiences and clinical outcomes.

The SPH committee structure ensures that a number of key governance committees include consumer participation.

Healthscope had developed a Consumer Consultant (CC) Position Description which details the role and responsibility of a CC. The broad role is expansive and includes: involvement in strategic and operational planning; reviewing/advising on safety, quality and performance data; reviewing/advising on communication material; providing advice to clinical craft groups; having input into orientation programs; serving on a range of committees; providing advice on policies and procedures; and being a consumer voice to management.

SPH has had active CCs for the last five years and each CC has fulfilled the requirements of their Position Description. Discussion with one CC at the assessment confirmed that she has been involved in all of the activities described above. Feedback from the executive team and clinicians confirmed that the CCs have provided valuable feedback and input to the various committees on which they serve.

CCs have their own orientation program which includes training on quality and safety and understanding of the hospitals Key Performance Indicator Dashboard data. CCs have access to the annual organisation-wide clinical and no-clinical training program.

COVID-19 has impacted on the increase in the number of CCs. At the date of the assessment there was only one CC and assessors noted that SPH is planning to increase the number of CCs to ten in the near future.

Patients/carers are made aware of their Rights and Responsibilities on admission and signage throughout the hospital. The intake and assessment processes ensures that informed consent and patient decision-making capacity is addressed.

Discussion with the CC at the assessment confirmed that in her opinion communication was well managed at all levels of the hospital.

Standard 3

Overall, the compliance with preventing and controlling Infections is very impressive, not only with the documented evidence but also with the patient journey and staff interactions that assessors experienced. Assessors were fortunate with the opportunity to undertake a patient journey looking with a consumer and staff perspective to identify and align all the National Safety and Quality Health Standards and its linkages across the journey.

The staff commitment within the clinical areas to ensuring infection control practices are implemented and monitored to reduce harm to patients and staff is commendable. Specifically, environmental cleaning practices and monitoring are of a very high standard. The concept of patient rounding with environmental cleaning is clearly a positive way to involve consumers to address any gaps or concerns with environmental cleaning. This, combined with the DAZO environmental auditing process and that gives feedback to staff on environmental cleaning practices, and the ability to identify and target specific staff education, results in high standards for environmental cleaning practices.

The CC participation with Infection Control Committee (IC) supports strong relationships with consumer involvement related to infection control.

The workforce education related to infection control practices is evidenced with high mandatory training results.

The Hand Hygiene results have improved and are currently at 82% after much diligence and work from the IC team with emphasis on medical staff Hand Hygiene compliance.

Transmission Based Precaution practices are up to date specifically with COVID-19 related practices.

The redevelopment of the Central Sterilising Services meets AS4187 advisories practices combined with the use of HICMR audit tools ensure good monitoring and compliance across all sterilisation processes of Reusable Medical Devices (RMD). Considering the high volumes of loan instrumentation, the robust processes that have been implemented ensure an efficient process with all RMD’S to ensure meeting AS4187 standard.

Improvement plans are in place to address gaps in Antimicrobial Stewardship with strong focus on VMO engagement.

As expected, the integrated risk register has identified world-wide shortage of wrap identified with ongoing minimisation strategies in place to mitigate risk to surgical activity.

Standard 4

HPS effectively support SPH in providing pharmacy and medication management. There has been significant improvement in medication errors over the past few years and a culture of continuous of improvement was evident. Changing the procurement process that is planned will add a further level of safety to the whole process.

There was a recommendation in relation to medication safety in theatres, from the last assessment, this has been closed with the changes that have implemented in the management of drugs of addiction and or identified as drugs at risk of abuse. Assessors have suggested further refinement of the management practice of those drugs that ensures safety and is compliant with policy, regulatory requirements and legislation.

Standard 5

Assessors noted that this Standard was well supported using the patient journey methodology and consumer feedback. There is a patient centric focus with appropriate risk assessment and monitoring. Staff are well supported by Education Services. The comprehensive care plan is well utilised although more attention to confirming the patient engagement would strengthen this. There is space on the forms to confirm the active engagement. Handover witnessed by all assessors was active with patients. Teamwork particularly between allied health and nursing staff was repeatedly demonstrated.

There is an awareness of cognitive impairment and management particularly delirium. Whilst there are few episodes of aggression staff capability to manage if it should present itself, could be strengthened with additional training in de-escalation of aggression.

Assessors agreed that end-of-life care was extremely well done, supported by corporate policy and resources, empathic and caring staff and a deep awareness of meeting patient/carer needs. Diversity was well catered for and appropriate placement of patients for excellent end of life care in the general wards and in maternity was articulated.

Standard 6

There are systems in place to ensure staff deliver comprehensive care through the development of evidence-based policies/procedures which include screening and assessment processes agreed care goals, comprehensive care planning and management of end-of- life care. There are a range governance and operational clinical committees charged with the responsibility for ensuring information flows across the hospital.

Clinical procedures are consistent with best practice in admission processes, comprehensive assessments, risk assessments, care plan development and discharge and referral processes.

The introduction of the three times per day huddle process, patient handover and multidisciplinary team discussions has allowed for a wholistic approach to patient care which was very evident during assessment. It was very evident that patients are involved in contributing to their own care and discussions/concerns about their care.

There are effective systems in place for the transfer of care to other hospitals if a higher level of care is required and to external community services.

Medical records are paper based and are well managed by the Medical Records Unit.

Standard 7

The Management of Blood within SPH is supported with excellent documentation and daily auditing processes supported by QML. Blood wastage is minimal with excellent pathways to obtain blood for Massive Transfusion protocol as evidenced with recent sentinel event, Massive Transfusion Protocol.

Standard 8

This Standard has a well prepared and responsive staff and a well-documented pathway. Use of track and trigger charts, exclusion criteria, appropriate MET calls, access to ICU skills and knowledge all contribute to the effectiveness of recognising and responding to the deteriorating patient. There is a deficiency in suitably trained mental health clinicians on staff however good links and referrals are in place to escalate care if required. PACE Posters are in place and made explicit to consumers and their families or carers.

Some minor changes to the paediatric ward area were recently made to improve safety. Staff have paediatric life support skills, and the emergency trolley is specific for paediatrics. Maternity staff have maternal and neonatal advanced life support skills, and they are supported by ICU staff in the event of an obstetric emergency.

A sentinel event that recently occurred was communicated to all of the assessors independently and separately. This served to demonstrate effectively how well the emergency response worked and whilst the RCA and Coroners Report have not been completed minor changes have been implemented from lessons learnt to improve safety and response to acute deterioration of a patient.

Summary of Results

At Sunnybank Private Hospital's Organisation-Wide Assessment all actions were met, with two Actions 1.1 and 5.5 rated Met with Recommendation across the 8 Standards. Sunnybank Private Hospital was well prepared for this assessment and presented a whole of organisation approach to safety and quality and demonstrated their patient centred model of care, improvements, monitoring and reporting processes to assessors during operational visits and interviews. The evidence was presented clearly and accessibly. Assessors were impressed by the passion in which all staff have for caring for their patients and working with patients/carers to achieve best patient-centred care outcomes.

The following table identifies the Actions that were rated Met with Recommendation and lists the facilities to which the rating applies.

Actions Rated Met with Recommendations

Facilities (HSF IDs)	NS2 OWA 15/06/2021 - 17/06/2021
	MwR
Sunnybank Private Hospital-101177	1.1, 5.5

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

Sites for Assessment

Sunnybank Private Hospital

Site	HSFID	Address	Visited
Sunnybank Private Hospital	101177	245 McCullough Street SUNNYBANK QLD 4129	Yes

Standard 1 - Clinical Governance

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

ACTION 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Comments	**Suggestion(s) for Improvement**
The new Healthscope Clinical Governance Plan 2021-2025 (the Plan) is very new and well developed and appears to meet the current needs of Healthscope. The Plan is a Consumer Approved Publication. The Sunnybank Private Hospital CGP is aligned to the Healthscope Plan and at the date of the Assessment was being implemented. There was evidence that there has been some staff training on the new CGP at Sunnybank Private Hospital (SPH), but assessors agreed that the CGP will take time to implement and eventually evaluate the effectiveness of the SPHCGP. A culture of safety and quality improvement which align to the Values of Healthscope exists at all levels of Sunnybank Private Hospital (SPH) There is a strong governance model which is evidenced in the Healthscope Clinical Governance Plan-2021-2025 (Consumer Approved Publication) and the SPH Clinical Governance Plan-2021-2025 (Consumer Approved Publication). Both plans are new, and a recommendation has been made to address this issue. OneHealthscope 2025 has a range of key pillars and objectives with two major objectives. The annual SPH Strategic Plan aligns to OneHealthscope 2025. Quarterly Clinical Quality Key Performance Indicators (KPI's) are provided to the Healthscope National Quality Committee, SPH Executive Committee and the SPH Quality, Risk and	

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		
Consumer Committee. There is a range of clinical and non-clinical dashboard information reviewed by the Board and the SPH Executive Team monthly. Policy/Procedure documents at a Healthscope and SPH level address safety and quality. The SPH Consumer Partnership Plan 2020-2023 sets out practical strategies for partnering with their consumers to improve patient experiences and clinical outcomes. The establishment of clinical craft groups which include the opportunity for consumer participation demonstrate the commitment of SPH to consumer participation on clinical governance and was favourably commented on by the Consultant Consumer (CC) present at the assessment.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	All	**Recommendation:** Continue to implement and evaluate the effectiveness of the Clinical Governance Plan 2021-2025. **Risk Rating:** Low

<table>
<tr><th colspan="2">ACTION 1.2</th></tr>
<tr><td colspan="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</td></tr>
<tr><th>Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td>There is an Aboriginal and Torres Strait Islander (ATSI) Reconciliation Plan which has been endorsed by Reconciliation Australia. There is a Healthscope Reconciliation Working Group to assist hospitals via the online via Webex® forum. A review of admission data showed that ATSI admissions to SPH are less than 1%.

Notwithstanding approaches have been made by the SPH to the Yagura people to foster and engage a mutually supportive and beneficial relationship. Staff have tried to make the hospital and grounds a welcoming environment and culturally sensitive for ATSI patients. SPH has commissioned a painting which is displayed in the main foyer and the indigenous flags are at every reception counter.

SPH has developed a relationship with the Aboriginal Liaison Officer (AL0) at the local public hospital. The ALO has aided in reviewing and approving the general health information for ATSI communities.

Part of the SPH Action Plan to encourages ATSI persons to declare their Aboriginal status.

Assessors agreed that SPH complies with the intent of Advisory AS18/04.</td><td></td></tr>
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Rating	Applicable HSF IDs
Met	All

ACTION 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	**Suggestion(s) for Improvement**
There is a documented organisational and committee structure SPH. The structure is aligned to the SPH Clinical Governance Plan 2021-2025 (CGP) There are five committees at SPH that review quality and risk. Assessors reviewed a selection the minutes of each of the committees. Minutes are in Action format to ensure decisions are followed through. The CGP documents improvements and safety. All staff Position Descriptions include responsibilities for improving safety and quality. Visiting Medical Officers (VMOs are made aware of their responsibilities for improving safety and quality as part of their credentialling and appointment process. There are a range of audits aligned to each NSQHS Standard. The results of audits are reviewed by the relevant Committee and relevant staff and/or Craft Groups.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	**Suggestion(s) for Improvement**
Refer to comments in 1.2. There are no specific risk issues associated with ATSI persons. There are a range of patient risk assessments as part of the intake/admission process that are applied to all patients. Assessors agreed that SPH complies with the intent of Advisory AS18/04.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.5		
The health service organisation considers the safety and quality of health care for patients in its business decision-making		
Comments		**Suggestion(s) for Improvement**
The OneHealthscope 2025 (the Plan) documents how Healthscope implements its two major objectives. There are six key pillars that operationalise the strategic intent of the Plan. The patient centred care pillar is further strengthened using patient survey dashboards and the practice of considering patient experience feedback as a way of demonstrating good quality clinical outcomes and sound business practice. The Board and SPH Executive Team are provided with a suite of activity, financial and trended dashboard data to monitor the performance of each entity and comparative data with other Healthscope hospitals. The recent SPH Patient Survey data indicates an 82.7% level of satisfaction for 17 questions. In addition, the adverse event rate for 2019 was 1.5% as compared to the AIHW rate of 3.8%.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	**Suggestion(s) for Improvement**
All staff have current Position Descriptions which specify their responsibility in quality and safety. Annual Performance Review and Development (PRD) is conducted. At the date of the Assessment 61% of staff had completed their Performance Review and Development and an Action Plan viewed by assessors confirmed that all staff reviews would be completed by 31 July 2021. Visiting Medical Officers (VMOs) comply with the Healthscope By-laws 2018.	

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	
SPH Orientation Programs include information of safety and quality. All committees have a standing agenda item on quality and on safety. Training has commenced on SPH CGP. Mandatory training requirements are determined as part of the annual PRD process and on the basis clinical and operational risk minimisation and compliance with standards and legislation. Assessors were very impressed with the passion of the Clinical Education Team and the quality of training sessions. Assessors noted that the various Craft Groups provide an excellent learning forum for clinicians and are well attended by staff, VMOs and on occasions the CCs. Clinical Audits are discussed at relevant committees and Craft Groups. SPH is a small friendly facility with a significant number of longstanding staff. Pride in the facility and in each other's work was very evident.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Comments	**Suggestion(s) for Improvement**
Healthscope and SPH have current, comprehensive and effective policies and procedures which are available to all staff via the Healthscope intranet (HiNT). Staff interviewed were able to show how to they could access policies/procedures. Policies/Procedures are document controlled and there is a review date.	

Org Name : Sunnybank Private Hospital
Org Code : 721758

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	
SPH policies/procedures are reviewed by the Policy, Forms and Documentation Committee. Compliance with policies/procedures are audited with results being reviewed by a range of committees- Quality Risk and Consumer Committee, Hospital Executive Committee, Medical Advisory Committee, Craft Groups and Workplace Health and Safety. Assessors reviewed a selection the minutes of each of the mentioned Committees. Staff are informed of changes in policies/procedures or a new policy/procedure via HiNT, team meetings, emails, internal newsletters and craft meetings. Staff interviewed and the Chairman of the MAC indicated that there were very good communication processes at all levels of SPH.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Comments	**Suggestion(s) for Improvement**
The Managing Risk element of the CGP documents how to manage, report, analyse incidents, share learnings arising from incidents to deliver harm-free care. There are a range of written and observations audits which align to each NSQHS Standard. The results of audits are reviewed by the relevant Committee and relevant staff and/or craft groups. Discussions with staff indicated a good level of awareness on quality and safety and their involvement in the various audits, outcomes, education and processes.	There are a range of graphs produced which show the various KPI'S of all the organisations' hospital performances. It is suggested that consideration be given to produce graphical data for SPH which includes the National KPI benchmarks. This will allow the SPH to see their trended data and how the compare to the other hospitals in the Group.

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	
	It is also suggested that the graphs be displayed throughout the hospital to showcase SPH outcomes.

Rating	Applicable HSF IDs
Met	All

ACTION 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	**Suggestion(s) for Improvement**
SPH contributes to the monthly Board Quality KPI Dashboard Report and reports against 26 core indicators, ACHS Clinical Indicators, patient feedback, sentinel events, hospital acquired complications, audit results and shared learnings. Data graphs are trended and SPH data is reviewed and discussed by the SPH Executive and relevant information is shared with the staff. There are Care Boards based on the 8 NSQHS Standards in each public area and are updated monthly and have a section for specific focusses and actions relevant to each ward/department for that month. Staff commence each clinical handover at these Boards, and this was witnessed by assessors.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.10		
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters		
Comments		**Suggestion(s) for Improvement**
There are a range of policies/procedures to document risk management. Staff have been trained in understanding the policies/procedures and how to report incidents and sentinel events. Potential patient risks are identified as part of the admission and assessment process. Organisational risks are identified through several processes and are listed in the Integrated Risk Register (IRR). The IRR complies with AS/ISO 31000;2018. The IRR is regularly reviewed by the Executive Team. A range of audits are in place to measure the effectiveness of the risk management system. Action in the Event of an Emergency signage is located throughout the hospital and Emergency Code Flip Charts are available adjacent to all phones. Mandatory annual staff training in emergency procedures is current. There is a Business Continuity Plan in place. SPH complies with the requirements of Advisory AS18/09.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Comments	**Suggestion(s) for Improvement**
There are a range of policies/procedures in place that document the identification, assessment, care and reporting processes for incidents, sentinel events and any other	

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	
untoward event. All incidents are recorded in RiskMan which is regularly revied by the Executive Team. Incidents are reviewed by several Committees-Medical Advisory, WHS, Emergency and Radiation and Laser Safety, Quality, Risk and Consumer any relevant Craft Group. A recent Sentinel event in theatre was shared with the assessors detailing each step of the incident from the initial start to the finish including open disclosure, support for the family, the clinical team by colleagues and the employee assistant counselling service. The action taken was in accordance with Healthscope policies and the process had begun to establish and RCA investigation. Assessors were very impressed at the way the event was managed and the level of support for all who were involved in the unfortunate incident.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	**Suggestion(s) for Improvement**
Outcomes from SAC 1 and SAC 2 incidents are part of the shared learnings process and are reviewed and discussed at the MAC. Executive Team Committee and relevant Craft Group. The June 2021 patient experience data showed a high-level satisfaction to the comment ‘I was informed as much as I wanted about my treatment and care’.	

Rating	Applicable HSF IDs

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

ACTION 1.13		
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems		
Comments		**Suggestion(s) for Improvement**
The ‘Back to Bedside’ approach consists of five components for obtaining regular patient feedback: standard communication; rounding; bedside handover; patient care boards; and acts of kindness. Assessors witnessed several handovers which involved communication with each patient. The June 2021 patient experience data showed a high-level satisfaction to the comment ‘As far as I could tell, the staff involved in my care communicated with each other about my treatment’ and ‘I was involved as much as I wanted in making decisions about my treatment and care’. All staff are involved in the safety and quality processes of SPH either by various committee/craft group involvement, team meetings or the annual ‘Your Voice Counts’ Survey.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	**Suggestion(s) for Improvement**
There are several policies/procedures that document the management of complaints. Complaints are uploaded and tracked through RiskMan. The By-laws also describe the complaints process where there are complaints about a VMO. Complaints are included and trended in the Board Dashboard data. Patients are also encouraged to provide feedback online shortly after discharge. The introduction of the' Back to Bedside' approach ensures that patients are given knowledge of how they can provide complaints or compliments. A review of the June2010 Patient Experience data by assessors indicated a high level of satisfaction with the staff and services offered at SPH. The 1000hrs Daily Bed Activity review by service managers also provides an opportunity for any complaints to be noted and addresses.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	**Suggestion(s) for Improvement**
The SPH primary catchment area is reasonably stable in population growth and has a higher socio-economic community profile than the Queensland population. English and Mandarin are the predominant languages. There are a range of brochures and information data in English and Mandarin and there is access to interpreter services or consumer advocacy services.	

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		
There is a good range of user- friendly information available to ATSI persons and there is access to Aboriginal Liaison Services at a local public hospital.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.16		
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used		
Comments		**Suggestion(s) for Improvement**
Patient medical records are paper based and are available at the point of care. There are several policies/procedures relating to the management of medical records and privacy rules. There is an FOI process in place for patients and other relevant parties. Patient medical records not in use are securely stored and access is controlled. Clinical Coding is in place in accordance with Queensland Health Guidelines. There are several medical record audits to ensure records align to the various policies/procedures. Records are comprehensive and include all data needed to ensure the right care for the right person. There are two Clinical Documentation Specialist who are responsible for monitoring the standard of documentation.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	**Suggestion(s) for Improvement**
The front office admission staff manage the intake process for MyHealth Record (MyHR) and enter the patient's input data and subsequent discharge data. Patients are given a copy of the 'All you need to Know' brochure' and admission staff provide any answers to questions a patient/carer or family may ask. SPH complies with requirements of Advisory AS18/11.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	**Suggestion(s) for Improvement**
The MyHealth Record Policy documents the authorised access to each patient's MyHR. Access is password protected and there is an access hierarchy in place. The Australian Commission on Safety and Quality in Health Care audits the quality of the Event/Discharge Summaries that are uploaded to MyHR. Healthscope has two external providers who provide advice on IT and Cyber Security. SPH complies with requirements of Advisory AS18/11.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	**Suggestion(s) for Improvement**
The details in relation to the Healthscope Board are documented in the Healthscope NSQHS Standards Report and not included in this section of this report. SPH has current Position Descriptions for all staff and there is an extensive Orientation Program. Performance Review and Development occurs annually. Mandatory staff education covers a range of clinical and non-clinical modules including modules on quality and safety. VMOs are appointed in line with the By-laws and credentialing process via the Credentialing Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Comments	**Suggestion(s) for Improvement**
Assessors reviewed mandatory training records and noted a 98% level of staff compliance (the Healthscope benchmark is 92%) Quality and safety are components of the Mandatory Training Schedule. Intensive training requirements are identified either by audit results, incidents, sentinel events or other identified clinical deficits.	

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		
SPH has a Staff Development Service with two qualified educators and assessors were impressed by the passion they have for ensuring SPH staff are at the forefront of up-to-date clinical practice. The Staff Development Educators have developed several competency Assessment Tools for clinical services. VMOs are required to comply with Continuing Medical Education in line with requirements of their respective College.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.21		
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients		
Comments		**Suggestion(s) for Improvement**
Whilst the number of ATSI patients is very low SPH has implemented a number of cultural safety awareness process: non-clinical administration staff completed 'Asking the Question-Are you of ATSI descent; all staff are required to complete 'Share the Pride' training; National Reconciliation week morning tea with video; art work on the main foyer of the hospital; posters advertising NAIDOC week; distribution of the Healthscope Reconciliation Plan; and the indigenous flags are at every reception counter. Assessors agreed that SPH complies with the intent of Advisory AS18/04.		
Rating	**Applicable HSF IDs**	
Met	All	

<table>
<tr><td colspan="3">ACTION 1.22</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="2">Comments</td><td>Suggestion(s) for Improvement</td></tr>
<tr><td colspan="2">At the date of the assessment 61% staff had completed their Performance Review and Development and an Action Plan viewed by assessors confirmed that all reviews would be completed by 31 July 2021.</td><td></td></tr>
<tr><td>Rating</td><td colspan="2">Applicable HSF IDs</td></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

<table>
<tr><td colspan="3">ACTION 1.23</td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="2">Comments</td><td>Suggestion(s) for Improvement</td></tr>
<tr><td colspan="2">Clinicians are appropriately skilled and experienced to perform their roles safely and to provide services within an agreed scope of practice. The Medical Credentialling Committee manages medical appointments in line with the role and clinical capability of the hospital and the annual Strategic and Business Plan. Medical staff are appointed for a three or five-year period. Staff have access to scope of practice details in webPAS and key staff have access to eCredentialing.

The MAC reviews any new clinical procedure request/s in line with Healthscope Policy New Interventional Procedures.

Nursing and Allied Health staff are all registered with AHPRA. Some staff undertake professional supervision.</td><td></td></tr>
<tr><td>Rating</td><td colspan="2">Applicable HSF IDs</td></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	**Suggestion(s) for Improvement**
Refer Action 1.23. The SPH General Manager in consultation with the Chairman of the MAC manage the requirements of this Action. SPH complies with the requirements of Advisory AS18/12.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	**Suggestion(s) for Improvement**
The SPH CGP documents the hospitals quality and safety processes. Position Descriptions include safety and quality and safety requirements. The By-laws and VMOs' contracts include quality and safety requirements. All orientation programs include a session on quality and safety. Annual ongoing training includes sessions on quality and safety. There are several communication tools which are used to ensure that quality and safety is paramount for all staff and VMOs: outcomes from various audits; committee meetings; Healthscope 'The Pulse' magazine; SPH electronic newsletter; Craft Group meetings; Webex forums; and eLearning training packages. Assessors reviewed some of the documents and confirmed that the staff and VMOs are well informed about quality and safety.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26		
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate		
Comments		**Suggestion(s) for Improvement**
Professional skills are documented in Positions Descriptions or each VMOs' Contract. At the date of the assessment 61% staff had completed their Performance Review and Development and an Action Sheet viewed by assessors confirmed that all reviews would be completed by 31 July 2021. VMO reviews are part of the credentialling process. Medical staff comply with Continuing Medical Education in line with requirements of their respective College.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.27		
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care		
Comments		**Suggestion(s) for Improvement**
SPH has access to a range of national and local clinical guidelines which are available to staff on HiNT. There is an audit process in place to ensure staff and VMOs use the guidelines. Changes in guidelines or clinical practices are discussed at the relevant committees and the Craft Groups. Where applicable clinical policies/procedures reference National Guidelines. There are a range of assessment tools designed to meet national guidelines. SPH complies with the requirements of Advisory AS18/12.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Comments	**Suggestion(s) for Improvement**
The Board Quality and Safety Dashboard contains data for all Healthscope hospitals which allows each hospital to see their data as compared to the other hospitals on the group and this allows for discussion/action at the relevant SPH committee. SPH provides data the ACHS Hospital Wide Clinical Indicator Program. A review of the latest ACHS Clinical Indicator Report shows many indicators in line with expected outcomes and some that need attention. Those requiring review and attention are referred to the Executive Team, MAC relevant Craft Group. SPH participates in several National Registries reflective of the clinical profile. Morbidity and Mortality reviews are managed by the MAC. Discussions with the Chairman of the MAC confirmed the role of the MAC in incident management and sentinel events. SPH complies with the requirements of Advisory AS18/12.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Comments	**Suggestion(s) for Improvement**
There is a Preventive Maintenance Program and a Breakdown Maintenance Program in place. Some maintenance works are completed in-house and some works are contracted. Contractors are engaged after an extensive selection process and are evaluated annually.	

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		
There is a system to ensure Contractor licences, registrations and insurances are current. Fire Reports dated 04/01/2021, 08/01/2021 02/03/2021 showed compliance. Staff and the CCs are involved in relevant equipment purchases and any capital building works. Major New Equipment is identified via a scope of works and a tender process is in place with the final decisions being made by the Board or the SPH Executive Team. Staff are trained in the use of new equipment. The hospital is clean and well maintained.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.30		
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required		
Comments		**Suggestion(s) for Improvement**
There is a system for staff to report safety or security issues which are risk rated and a system to ensure that issues are dealt with in line with the risk rating. The Workplace aggression and violence- principles and prevention Policy is in place and staff have had training in the Policy. Night-time security practices are in place and audited every month.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.31		
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose		
Comments		**Suggestion(s) for Improvement**
There is good external signage to locate the hospital and good internal throughout the hospital. The hospital and grounds are welcoming.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.32		
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients’ needs, when it is safe to do so		
Comments		**Suggestion(s) for Improvement**
SPH provides flexible visiting arrangements with information provided on the SPH website, admission information brochure, on the telephone hold call system and included in the patient bedside compendium. Fathers on new babies are encouraged to stay overnight with sleeping arrangements (some double beds) and catering arrangements. Extended visiting hours are available to families whose family member has cognitive impairment or receiving end-of-life care.		
Rating	**Applicable HSF IDs**	
Met	All	

<table>
<tr><th colspan="2">ACTION 1.33</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><th>Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td>SPK has taken initiatives to implement the intent of this Action: non-clinical administration staff completed ‘Asking the Question-Are you of ATSI descent; all staff are required to complete ‘Share the Pride’ training; National Reconciliation week morning tea with video; artwork on the main foyer of the hospital; the indigenous flags are at every reception counter; Indigenous status as asked of all staff at their intake process. Assessors were advised that there have been a small number of staff who had not recently declared the Aboriginal Status declaring and offering to assist with Aboriginal cultural training for staff in the future.

Assessors agreed that SPH complies with the intent of Advisory AS18/04.</td><td></td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	**Suggestion(s) for Improvement**
Healthscope have a Consumer Engagement Plan (CEP) that details the corporate strategies for ensuing both corporate and clinical governance of consumer partnerships. Healthscope has engaged Consumer Consultants (CC) at a corporate level and hospital level. The SPH Consumer Partnership Plan 2020-2023 documents the processes for involving consumers at a governance and operational level. SPH has had two active Consumer Consultants for 5 years although 2020 has seen a reduction to one due to personal reasons. The current CC (a registered nurse and midwife) participated in the assessment of this Standard. There is a current CC Position Description and an extensive orientation program which includes a session on quality and safety which was confirmed by the CC who participated in the assessment. CC's have access to the SPH Training Calendar and can participate in any training they see as relevant. A review of minutes of the SPH Quality, Risk and Consumer Committee clearly document the involvement of the CCs in the governance and operations of the hospital. The CC interviewed confirmed that she has been involved in many hospital activities. Some but not all being: strategic planning processes, Quality and Safety Plan input; publication reviews; some internal audits, dietary review of oncology patients, environment reviews; review of the 'Back to Basics' project; revision of the CC Orientation Program; clinical handover procedures; and changes in some clinical practices.	

Org Name : Sunnybank Private Hospital
Org Code : 721758

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		
There is an annual Consumer Focus Group Schedule for the Craft Groups to assist in CC planning. Patient/carer feedback is also obtained from: bedside handover; patient rounding; and patient experience surveys.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	**Suggestion(s) for Improvement**
Feedback from the Executive Team indicated that the present system of CCs was effective, and each CC has performed their role in accordance with the Position Description and have provided valuable feedback and input to the various committees they attend. CCs are members of the Quality, Risk and Consumer Committee and are provided with all the quality and safety data, incident, complaints. patients experience survey results, craft group minutes. The CC interviewed advised she understood all the data being presented and had no problems of asking questions on matters that she required clarification. She also advised assessors that she considered her input was appreciated and valued. The June 2021 Patient Experience Survey had an overall 'very good' score for the following questions: I was involved as much as I wanted in making decisions about my care; 'I was kept informed as much as I wanted about my treatment and care' and	

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	
'My views and concerns were listed to'. The same survey had the overall Quality of Treatment and Care at 90.1%.	

Rating	Applicable HSF IDs
Met	All

ACTION 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Comments	**Suggestion(s) for Improvement**
The Charter of Healthcare Rights is on display throughout the hospital. All patients are given a copy of the Healthscope Rights and Responsibilities Brochure on each Admission. Patients interviewed during the assessment were aware of their Rights and Responsibilities.	

Rating	Applicable HSF IDs
Met	All

ACTION 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	**Suggestion(s) for Improvement**
SPH has a range of Consent Forms. VMOs are responsible for ensuring their patients sign a consent from prior to admission. The admissions staff ensure the Informed Financial Consent Form is understood by the patient before the patient signs the form. All patients receive a copy of their Consent Forms. Interpreters are available to patients if needed.	

ACTION 2.4		
The health service organisation ensures that its informed consent processes comply with legislation and best practice		
There is an annual Consent Audit with established compliance benchmarks. There is a Compliance Officer to ensure that informed consent processes comply with legislation and best practice. SPH complies with Advisory AS18/10.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.5		
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves		
Comments		**Suggestion(s) for Improvement**
VMOs have the responsibility to ensure the consent forms are signed by the patient or if the patient does not have capacity by the alternate decision maker. Consent Forms are part of each patient's medical records their Care Plan has details of who is the decision maker. Staff have had training on assessing patient capacity- there are a range of cognitive impairment and mini mental tools. See comments in 2.2 concerning patient involvement in care. SPH has a register of advocacy and support services available to patients/carers/ decision makers. The Medical Records Unit has a range of security policies and processes in place to ensure the privacy of a patient's record before release to a third party.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.6		
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care		
Comments		**Suggestion(s) for Improvement**
Clinical care is discussed with each patient and is recorded in their Comprehensive Care Plan (CCP). CCPs are goal based and there are regular multidisciplinary team discussions to ensure care is in line with goals. Care is monitored daily, and the handover process ensures that patients are involved in their own care. Assessors noted the interaction between staff and patients at several handovers. The June 2021 Patient Experience data rated a high level of satisfaction for two relevant indicators – 'I was involved as much as I wanted in making decisions about my care' and "I was kept informed as much as I wanted about my treatment and care'.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.7		
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care		
Comments		**Suggestion(s) for Improvement**
Patient Experience is one of the key elements of the SPH Clinical Governance Plan 2021-2025. Staff, VMOs and the have all had training patient-centred care at their initial orientation. The SPH Clinical Partnership Plan lists five initiatives to support consumer partnerships- bedside handover, patient rounding, patient-centred care strategies and patient satisfaction. Consumer approved publications and engaging consumer consultants at all Healthscope hospitals. Assessors witnessed all five of these strategies in action. SPH patient feedback on their overall quality treatment has been above 85% since April 2021.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.8		
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community		
Comments		**Suggestion(s) for Improvement**
The SPH primary catchment area us reasonably stable in population growth and has a higher socio-economic community profile than the Queensland population. English and Mandarin are the predominant languages. There are a range of Brochures and information data in English and Mandarin and there is access to interpreter services or consumers advocacy services. There is a good range of user-friendly information available to ATSI persons and there is access to Aboriginal Liaison Services at a local public hospital.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.9		
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review		
Comments		**Suggestion(s) for Improvement**
Discussions with the CC indicated that there has been a significant involvement in a range of communication information. Some but not all being: admission brochure, rights and responsibility brochure, cardiac program booklet, patient bedside compendium; end of life package; oncology package; cognitive impairment, privacy brochure, falls; and the ‘back to basics’ project. All reviewed documents have the Consumer Approved Publication Logo attached.		
Rating	**Applicable HSF IDs**	
Met	All	

Org Name : Sunnybank Private Hospital
Org Code : 721758

ACTION 2.10		
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge		
Comments		**Suggestion(s) for Improvement**
This Action is well addressed. Consumer Consultants have participated in: Craft Group discussions; the development of the Bereavement Pathway, the End-of-Life Package, and the Oncology Package. The SPH Maternity Midwives invited former patients to a morning tea 'to gain feedback on what we do well and how we can do better to improve your experience'. Documentation audits are in place to ensure compliance with relevant policies/procedures. All patients receive a copy of the Nursing Discharge Summary, and a copy is sent electronically to their GP and MyHR if consent has been given. The June 2021 Patient Experience Data shows a high level of satisfaction to the question 'I was kept informed as much as I wanted about my treatment and care'.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Comments	**Suggestion(s) for Improvement**
Discussion with the Consumer Consultant confirmed that she had been involved in the development of the SPH Clinical Governance Plan 2021-2015 and the SPH Consumer Partnership Plan 2020-2023. CCs were also involved in the room audits to advise on appearance and impressions which resulted in changes to the décor and furnishings of some rooms.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	**Suggestion(s) for Improvement**
CCs are appointed in accordance with the Position Description which in part requires people with 'lived experience'. There is an extensive orientation program which included information on quality and safety and their role in participating in the quality and safety program of the hospital. As mentioned, they are assigned to various committees and contribute to the business of the respective committee. CCs have access to the SPH Training Calendar and can participate in any training they see as relevant. Their involvement in Craft Groups is seen as a very positive way of providing feedback to improve the effectives of care provided by clinicians. COVID-19 prevented the employment of additional CCs. At the date of the assessment SPH have commenced in the interview process for 10 additional CCs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	**Suggestion(s) for Improvement**
Assessors were advised that there have been a small number of staff who had not recently declared the Aboriginal Status declaring and offering to assist with Aboriginal cultural training for staff in the future. SPH is currently working on a project to improve reconciliation planning with the Brisbane Private Hospital. The first meeting with Elders was held in April 2021.Arrangements are in place to try and recruit an Aboriginal CC. Assessors agreed that SPH complies with the intent of Advisory AS18/04.	

Rating	Applicable HSF IDs
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	**Suggestion(s) for Improvement**
CCs have access to the SPH Training Calendar and can participate in any training they see as relevant. CCs were involved in the Oncology Package and the End-of-Life Package which were education Packages for patients.	

Rating	Applicable HSF IDs
Met	All

Org Name : Sunnybank Private Hospital
Org Code : 721758

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Comments	**Suggestion(s) for Improvement**
SPH has supporting policies, procedures and has identified risks related to Infection control practices with healthcare associated infections. SPH has full access to HICMR as part of the Healthscope corporate subscription which includes the policy and procedure manuals. Additionally, SPH also has access to both corporate Healthscope Infection Control Policies and local facility specific policies and procedures. Staff training statistics regarding Healthcare -associated infections and antimicrobial stewardship compliance is high.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Comments	**Suggestion(s) for Improvement**
SPH monitors healthcare-associated infections and effectiveness of antimicrobial stewardship with their annual infection prevention and Control Management Plan and associated audits.	

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		
All the infection control audits are tabled at the quarterly Infection Control Committee (ICC) with planned actions for improvement. Audits include HH, PPE, Invasive Devices, Waste Management, and Aseptic technique however an outstanding achievement with the environmental cleaning audits undertaken. Environmental audits are undertaken randomly, utilising a product that objectively measures cleaning thoroughness and allows real time feedback to take preventative action to and improve environmental cleaning to reduce associated risks. Recent HH audits identified a drop in compliance for last HH reporting quarter and quality improvement plan with initiatives were put in place with positive results of improved HH results during April (82%) with continued improvements, monthly reporting continues. SPH participates in many KPIs related to IC HAI, HH, HICMR recommendations and Immunisations are well evidenced.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	**Suggestion(s) for Improvement**
The inclusion of the concept of patient rounding with environmental cleaning is clearly a positive way to involve patients to address any gaps or concerns with environmental cleaning.	

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		
The ICC has a Consumer Consultant that is very active within the committee and Infection control practices and the overall IC Plan. Consumer focus is evidenced across infection control practices throughout the patient follows, involvement of patients with antimicrobial medications and discharge planning with medications; patient information brochures on all specific infections are available to staff and patients.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 3.4		
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups		
Comments		**Suggestion(s) for Improvement**
SPH has access to all HICMR HAI auditing tools which are currently undertaken by the Infection Control team and reported with relevant action plans to ICC (as evidenced though minutes). SPH also participates with Healthscope Infection Control KPIs including Hand Hygiene and Infection Control Risk assessments.		
Rating	**Applicable HSF IDs**	
Met	All	

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ACTION 3.5		
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements		
Comments		**Suggestion(s) for Improvement**
SPH has relevant TPB Procedure guidelines and training evidence related to Donning & Doffing Procedures aligning with Australian Guidelines for Prevention and Control of Infection. Standardised TPB practices have been implemented e.g. COVID air borne transmission; This has been visually evidenced with TBP signage and associated resources.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Comments	**Suggestion(s) for Improvement**
All patients undergo a screening process for MROS and any respiratory infections including COVID prior to admission. Any patient that has alerted to any TBP is flagged at admission and all appropriate processes put in place including single bed allocation with TBP signage. Patients are given explanations regarding any TBP practices with patient information brochures available. SPH has access to 24/7 HICMR and local Infection Control Manager to provide advice who also liaises with Infectious Disease expert as required. Robust processes are in place for the cleaning of TBP rooms during patient stay and post discharge with clear communication to all staff including cleaners where daily and terminal cleans are required.	

ACTION 3.6		
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements		
Cleaning staff have TBP cleaning practices at Orientation and as part of continuous training which is evidenced with training and audit results.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Comments	**Suggestion(s) for Improvement**
All clinical handovers including those at the bedside include infectious status of patients as evidenced during patient follow and any TBP is documented on the alert page of patient chart. The alert sheet is also used for either transfer or discharge of patients to their GP.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Comments	**Suggestion(s) for Improvement**
SPH Hand Hygiene program and practices are consistent with the National Hand Hygiene Initiative and with access though HICMR subscription to all resources. Evidence of HH posters, HH results on Quality Boards and appropriately placed Alcohol Based Hand Rub was visualised throughout the facility. Hand Hygiene (HH) promotions have been in place to improve HH practices and are currently sitting at 82% after much diligence and work from the IC team.	Continue monitoring ongoing monthly HH results with action plans to address any improvements to be implemented.

Rating	Applicable HSF IDs
Met	All

ACTION 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	**Suggestion(s) for Improvement**
SPH has an identified list of procedures requiring aseptic techniques and staff training for aseptic techniques compliance is high. All clinical staff training for aseptic techniques is captured electronically via ELMO and staff also undertake a practical assessment at orientation and then annually. Specific groups identify any additional aseptic training as required e.g. Maternity staff undertake epidural management. If gaps are identified in training, these are addressed with staff directly. Audits are undertaken for aseptic techniques utilising HICMR tools and any no-conformance is escalated though the ICC.	

Rating	Applicable HSF IDs
Met	All

ACTION 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Comments	**Suggestion(s) for Improvement**
SPH has access to Healthscope and HICMR Policies on invasive medical devices consistent with Australian Guidelines for the Prevention and Control of Infection in Healthcare. A process to identify any recall invasive medical devices is in place to ensure identified products are removed from clinical use promptly.	

Rating	Applicable HSF IDs
Met	All

ACTION 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Comments	**Suggestion(s) for Improvement**
SPH has full access to HICMR environmental cleaning policies, procedures, and toolkits aligning with Australian Guidelines for the Prevention and Control of Infection in Healthcare. Cleaning schedules for ward and speciality areas environmental cleaning evidenced. Robust training in environmental cleaning practices for the ward areas combined with the DAZO environmental auditing process gives feedback to staff on environmental cleaning practices. This has given the ability to identify and target specific staff education, this has resulted in high standards for environmental cleaning practices. All cleaning maintenance schedules such as water testing, Staff training in the use of PPE for all workforce has been undertaken as evidenced by training stats.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Comments	**Suggestion(s) for Improvement**
All cleaning maintenance schedules such as water testing, HEPA filter testing and Legionella testing are undertaken by external contractors and reports and any recommendations tabled at WH&S and Quality & Risk Committee. HICMR risk assessment related to sterilising processes has been updated with new CSU refurbishment. Mattress audits have been completed to identify mattresses requiring replacement. External linen services contracted with viewed ISO certification. Disposable linen utilised in Operating theatres and high-risk areas utilise disposable microbial curtains (all dated for replacement).	
Rating	**Applicable HSF IDs**
Met	All

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ACTION 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Comments	**Suggestion(s) for Improvement**
SPH utilises HICMR policies that align with Australian Immunisation Handbook. All staff must show evidence of vaccination/immunity on employment, or they are screened against listed diseases in the policy. A staff influenza program is in place and staff must evidence of immunisation.	

Rating	Applicable HSF IDs
Met	All

ACTION 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Comments	**Suggestion(s) for Improvement**
The SPH has a total CSSD refurbishment in 2018 after a previous gap analysis was completed for AS4187 and major works were required to meet all the requirements of AS4187. All AS4187 current advisories are met, with sterilising monitoring and validation processes present with excellent flow and documentation of all processes. The staff especially the CSSD NUM was very knowledge and up to date with current sterilising practices. Staff all undertake annual mandatory competencies and training which are audited and presented at the ICC. All flexible scopes are undergone routine channel washing testing which is also tabled at the ICC.	

Rating	Applicable HSF IDs
Met	All

ACTION 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Comments	**Suggestion(s) for Improvement**
SPH has policies for IMS and have access to electronic Therapeutic Guidelines available on all computers. Nurses stations also have quick refence guides available for VMOs to identify at point of prescribing. Reporting on AMS is tabled at both ICC and MAC to discuss any compliance AMS concerns for improvement. Results are also visual on the Quality Boards. AMS compliance is monitored with HPS pharmacy tools and a AMS has been included in the Integrated Risk Register to monitor results. Patients also are educated prior to discharge, and I visualised the patient pamphlet that discusses appropriate antibiotic usage after discharge. SPH complies with Advisory AS18/08.	

Rating	Applicable HSF IDs
Met	All

ACTION 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Comments	**Suggestion(s) for Improvement**
Continuous monitoring of appropriateness of antibiotics usage is discussed at MAC and with specific surgeons. VMOs have access to full therapeutic guidelines and AMS policies with associated posters. The clinicians have regular discussions highlighting the issues with compliance at the MAC regarding overall compliance with AMS; antimicrobial use; appropriateness of prescribing.	Continue monitoring with AMS audits ensuring a multidisciplinary approach to prescribing patterns and compliance to appropriate antibiotic usage.

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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	
AMS program is in place supported by a committee with associated improvement plans and Infection Control Team has targeted areas identified in audits requiring improvement especially within multidisciplinary teams with consumer engagement with decision-making re antibiotic usage.	

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

ACTION 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	**Suggestion(s) for Improvement**
Corporate and local policy and procedures are in place with support from the contracted pharmacy service (NPS) providing appropriate governance and management. Evidence was reviewed from NPS data to confirm timely and effective monitoring and processes relating to all aspects of medication safety including storage, dispensing, oversight of prescribing and administration. Training requirements are identified and acted upon with support from the Education Services. Online education is also available. Medication errors has been continuously improving between last assessment and this one with the incidence declining. Data from 2018-2020 was reviewed to confirm the improvements. Medication safety is embedded in reports to the governance committees and Healthscope corporate.	

Rating	Applicable HSF IDs
Met	All

ACTION 4.2		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management		
Comments		**Suggestion(s) for Improvement**
A Medication Safety Committee meets every two months. Risks are identified through patient assessment, medication histories and audit. Effective team communication, training and policy are utilised to address the risks. Assessment of risk is undertaken at preadmission or admission. and any Incidents are entered into RiskMan. The committee review all incidents. NPS monitor closely prescribing and administration with a recent introduction of more clinical pharmacy rounds. All patients with polypharmacy are reviewed by the onsite Pharmacists.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.3		
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making		
Comments		**Suggestion(s) for Improvement**
Patient engagement is evident through thorough medication history taking on admission, reconciliation and education. On site Clinical Pharmacists are active in supporting the medication safety of all patients who have multiple medications through regular rounding and meeting with consumers. The onsite Pharmacist provided evidence of ongoing education for patients and staff.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.4		
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians		
Comments		**Suggestion(s) for Improvement**
NPS provide credentialing for Pharmacists and SPH has appropriate competency assessment of nursing staff for administration. Safe administration of high-risk drugs was observed during assessment in theatres and oncology. Prescribing errors are few with an ongoing effort of improvement in completion of legible, appropriate charting. Pharmacy report the highest prescriber of medications has no errors recorded. Nursing staff refer to Pharmacists and garner support for any issues.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.5		
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care		
Comments		**Suggestion(s) for Improvement**
Comprehensive medication histories are collected and considered for safe patient care. Records reviewed had complete histories.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	**Suggestion(s) for Improvement**
At transitions of care medication safety is considered. Pharmacists are engaged where required. Should any changes in medication prescribing occur, comprehensive education and communication is provided including on the discharge summaries.	

Rating	Applicable HSF IDs
Met	All

ACTION 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Comments	**Suggestion(s) for Improvement**
All medication charts record any allergies and adverse reactions are reported through RiskMan. At all transitions of care including handover by shift, change in service delivery or intervention staff routinely asked of any history of allergies and confirm medications when necessary.	

Rating	Applicable HSF IDs
Met	All

ACTION 4.8		
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system		
Comments		**Suggestion(s) for Improvement**
The medical record is comprehensive and SPH has processes for documenting any adverse reactions. The incident is then entered in RiskMan, this is reviewed by pharmacy and the Executive Leadership Team. The Medication Safety Committee also review all events.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.9		
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements		
Comments		**Suggestion(s) for Improvement**
SPH reports adverse drug reactions to the TGA through the pharmacy service. Reports to the governing body also reflect any incidents.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.10		
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result		
Comments		**Suggestion(s) for Improvement**
Policy and practice was reviewed on site to confirm medication reviews are conducted, documented and address the patient's needs. There was consistency of practice, comprehensive documentation, appropriate charting and follow up of any incidents.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.11		
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks		
Comments		**Suggestion(s) for Improvement**
Education and support for patients was reviewed and noted to be delivered by pharmacists and nursing staff. Access to medication resources online and through pharmacy was available. Medication safety education services for staff also were noted to be in place.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	**Suggestion(s) for Improvement**
Medical records at SPH are hard copy. Patients supply a current medications list and are asked to bring their own medications with them to enable reconciliation. Patients own drugs are then stored appropriately in secure labelled bags in the medication rooms. Distribution of medicines to clinicians is a unique system that is in the process of being changed. Currently, imprest drugs are ordered via stores and distributed via stores to wards and theatre. There are checks and balances in place and drugs on receipt by the stores are in real time delivered to the appropriate areas. Restricted drugs are distributed via the Director of Nursing who accepts the delivery and signs off on ordering. The ordering is automated, and deliveries are every day. The system is moving to a pharmacy managed medication distribution system in keeping with the practice at other Healthscope sites.	Continue to Implement the pharmacy led system of complete medication management from ordering, distribution, dispensing and reconciling medication orders and usage.
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	**Suggestion(s) for Improvement**
Clinicians have access to pharmacy expertise and online resources including decision support tools. Staff are encouraged to seek advice should any aspect of medication safety be compromised.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14		
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines		
Comments		**Suggestion(s) for Improvement**
All jurisdictional and regulatory requirements were met by SPH for safe storage and distribution of medicines. Cold chain management was intact with fridges checked daily and recorded. Disposal of unused or expired medications was systematised. The imprest stock levels are maintained at appropriate levels for the throughput, so wastage is minimised.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 4.15		
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely		
Comments		**Suggestion(s) for Improvement**
High risk medicines are identified, and appropriate management is in place. Storage complies with Queensland regulations. Prescriptions are reviewed to ensure prescribers are authorised to prescribe. Nursing staff are trained and monitored in safe administration. In theatres the improved management of restricted and high-risk drugs has demonstrated effective compliance and management.		
Rating	**Applicable HSF IDs**	
Met	All	

Standard 5 - Comprehensive Care

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

ACTION 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Comments	**Suggestion(s) for Improvement**
Clinical governance is embedded in implementation of comprehensive care. Policy, procedures and clinical guidelines are in place, risks are identified, and an effective training program supports the compliance with Advisories AS18/14 and AS 18/15.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Comments	**Suggestion(s) for Improvement**
An audit program is in place to monitor aspects of comprehensive care. If any deficiencies are identified an action plan is drafted and implemented. Results of audits and performance are relayed to staff through ward meetings and Dashboards in the ward areas. In addition, rounding is used to monitor care delivery. Benchmarking against elements of Standard 5 demonstrates SPH is performing well against the overall Healthscope group.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.3		
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making		
Comments		**Suggestion(s) for Improvement**
Consumers are actively engaged in their care which was observed during assessment. Consumer information is reviewed by consumers and shared decision-making was observed during handover and with patient contact. Patients reported high levels of satisfaction with all services.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.4		
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients’ care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient’s care		
Comments		**Suggestion(s) for Improvement**
SPH has a comprehensive system of documents to assist clinicians in delivery of patient-centred care. In all areas visited by the assessment team patient centric care was observed, care plans were individualised, and patients were in the setting appropriate for their care. Referrals were documented, discharge planning evident and the clinician with overall responsibility for the patient’s care was identified.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.5		
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team		

Comments	**Suggestion(s) for Improvement**
The system for referral to ICU during the preoperative phase was on occasion not always effectively triaged. Communication relating to reasons for referral and risk factors occurred when the patient was escorted to ICU by the anaesthetist, post operatively. This creates a less than ideal environment of safe care in ICU and can lead to bed block if patients who do not require ICU care are admitted. This bed block can then result in patients with higher acuity being in ward beds without adequate safety measures in place.	

Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	All	**Recommendation:** A more robust system be implemented in relation to referrals to ICU. **Risk Rating:** Moderate **Risk Comment:** There is some evidence that there is some discussion in some cases but not all cases.

ACTION 5.6
Clinicians work collaboratively to plan and deliver comprehensive care

Comments	**Suggestion(s) for Improvement**
Collaboration and teamwork was evident in the ward areas however there was significant discussion in relation to the fragmentation of medical engagement. Medical referral was very much person based although Craft Groups meet quarterly and have a standing agenda. There is room for improvement in collegiality and collaboration. Many services are reported to reflect autonomous practice not collaboration.	

ACTION 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	**Suggestion(s) for Improvement**
The pre-admission process is strong, and all patients complete an initial online booking in following a referral from the specialist admitting the patient. (Patients without computers are assisted by staff). A comprehensive assessment occurs with any risks highlighted and managed effectively by the team. Poor outcomes for patients at risk of harm is rare. SPH complies with Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	**Suggestion(s) for Improvement**
Staff ask each and every patient if they identify as Aboriginal or Torres Strait Islander. This was confirmed by the assessment team reviewing patient records. Aboriginal and Torres Strait islander peoples are very rare (<1%) at SPH however consultation with local elders and plans for implementing a more welcoming and culturally	

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	
specific service was reflected in the Sunnybank Aboriginal and Torres Strait Islander Engagement Plan.	

Rating	Applicable HSF IDs
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	**Suggestion(s) for Improvement**
Advance Care planning is encouraged and supported, and a copy is placed in the notes on admission. This also includes identifying who is supporting the patient or their substitute decision maker.	

Rating	Applicable HSF IDs
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	**Suggestion(s) for Improvement**
Comprehensive screening occurs on admission and during the patient journey to mitigate any harm. Patient notes reflect the comprehensive identification of risk factors and care required.	

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		
An exclusion policy is in place for any patients who are too unwell for the facility, this particularly applies in assessing patients with mental health compromise and cognitive impairment. SPH complies with Advisory AS18/14.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.11		
Clinicians comprehensively assess the conditions and risks identified through the screening process		
Comments		**Suggestion(s) for Improvement**
The screening process is comprehensive, timely and documentation is readily available to support the delivery of care and mitigate risk.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.12		
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record		
Comments		**Suggestion(s) for Improvement**
Alerts in the medical record were noted to be clear and effective. The comprehensive documentation and follow through with care was noted in the review of records undertaken by the team.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Comments	**Suggestion(s) for Improvement**
A Comprehensive Care Plan is created for each patient and involves multidisciplinary input. Documentation of patient goals in the record was poor but goals were recorded with the patient each day on the Patient Care Board at the patient's bedside. More attention to confirming the consumer engagement would strengthen compliance with this action. There is space on the forms to confirm the active engagement. SPH complies with Advisory AS18/15.	All staff be supported to ensure documentation of consumer engagement and identification of patient goals occurs.

Rating	Applicable HSF IDs
Met	All

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	**Suggestion(s) for Improvement**
There was evidence that a patient centric model of care was in place at SPH. Feedback from consumers was overwhelmingly positive. Care is delivered according to the plan and patient wishes and re assessment occurs routinely and was observed to be well communicated during handover.	

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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		
The hospital is an area of high diversity and multiple language resources were noted and specific cultural needs being considered and met during a patient's stay. Maternity in particular has a very high percentage (>80%) of Chinese women accessing the services. A Mandarin speaking midwife was identified, in consumer feedback, as adding high value.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.15		
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]		
Comments		**Suggestion(s) for Improvement**
End-of-life care at SPH is an example of exceptional care. Staff spoke with empathy and demonstrated care and attention to patient and family needs. Unexpected deaths are uncommon. A comprehensive End-of-life Package has been developed by Healthscope, called Last days of Life Care. It has well-constructed forms including a MOLST (medical orders for life sustaining treatment) that are part of the medical record, enabling staff to have a concise record of the patient's condition, management, investigations required and organ donation intent. Care after death is also documented All elements of the National Consensus statement were evident in the Last days of life Toolkit.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.16		
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice		
Comments		**Suggestion(s) for Improvement**
Oncology services are provided at SPH and strong links occur with other sites for effective palliative care.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.17		
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record		
Comments		**Suggestion(s) for Improvement**
Advance Care Directives are received by the admitting clinician and a copy is in the patient' medical record.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	**Suggestion(s) for Improvement**
A recent Sentinel event in theatre was shared with the assessors. Support for staff was exceptional including the medical staff. Clinical supervision is accessible, and the leadership and management team demonstrated high levels of caring and follow up for staff.	

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	**Suggestion(s) for Improvement**
All deaths are reviewed and during the admission review of goals and quality of care occurs each day with the patient and their family. Specific cultural needs are accommodated, and staff reported being aware of various cultural differences at end of life care. A still birth or death of a neonate was discussed with staff providing opportunities to meet parent's needs. This included prolonging the time the patients have with their baby if they wish, using a specific crib with a cooling system.	1
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Comments	**Suggestion(s) for Improvement**
Clinicians are compliant with the essentials for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.21		
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines		
Comments		**Suggestion(s) for Improvement**
Screening for skin integrity risks occurs at admission and daily for those with more than a day's length of stay. Appropriate equipment is available to support high quality pressure mitigation.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.22		
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency		
Comments		**Suggestion(s) for Improvement**
Screening and treatment are in accordance with best practice.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	**Suggestion(s) for Improvement**
Information for pressure relieving devices, attention to risk areas and prevention of pressure injuries is part of patient and family education and occurs on admission, discharge and throughout the stay as required.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	**Suggestion(s) for Improvement**
Falls risk mitigation follows the NICE guidelines. Education was evident and attention to the environment to mitigate falls was noted during assessment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	**Suggestion(s) for Improvement**
Bed rails, height adjustment beds, handrails and other equipment was available. Falls are uncommon at SPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26		
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies		
Comments		**Suggestion(s) for Improvement**
Patient information is provided on admission and during a patient's stay, in particular when a patient has a heightened risk such as post anaesthetic.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.27		
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice		
Comments		**Suggestion(s) for Improvement**
Nutrition at SPH was well supported. A significant amount of Bariatric surgery is performed, and a dietician is available to oversee food and fluid intake. The kitchen takes great pride in providing the highest quality food that meets the patient's needs.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Comments	**Suggestion(s) for Improvement**
Fluid Charts are used. Specific nutritional needs are documented and supported. Patients requiring assistance are identified and staff assist.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Comments	**Suggestion(s) for Improvement**
Delirium is not a frequent event although staff could identify some occasions where a patient presented with same. Staff are trained to detect and support cognitive impairment. As noted in Standard 8, mental health decline is not as well established. A patient safety focus is used to mitigate any damage to the patient or staff. Duress alarms are in the ward areas. Restraint is not used. Anti-psychotic medications are not prescribed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.30		
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care		
Comments		**Suggestion(s) for Improvement**
Assessment on admission includes screening for risk of delirium. Families are supported should the patient present during their stay with delirium.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.31		
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed		
Comments		**Suggestion(s) for Improvement**
Screening for mental health issues occurs on admission however screening for suicidal ideation is not specifically undertaken. Should a patient be assessed as at risk of suicide, self-harm or discuss same, mental health services would be sought from other services external to SPH and the patient transferred.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.32		
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts		
Comments		**Suggestion(s) for Improvement**
Discharge planning is comprehensive and timely. Any patient who was at risk of self-harm or suicide would be escalated for care.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.33		
The health service organisation has processes to identify and mitigate situations that may precipitate aggression		
Comments		**Suggestion(s) for Improvement**
Training in deescalating aggression has not been a high priority and not all staff have developed skills in this area.		Provide minimising and de-escalating aggression training to staff to enhance their skills in this area.
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	**Suggestion(s) for Improvement**
Aggression is reported to be rare, however risk of aggression is considered through the assessment, during admission and during the hospital stay. Minimising harm to the patient staff and others is the focus of care.	

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

ACTION 5.35		
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body		
Comments		**Suggestion(s) for Improvement**
No restraint is used at SPH.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.36		
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body		
Comments		**Suggestion(s) for Improvement**
No seclusion is used.		
Rating	**Applicable HSF IDs**	
NA	All	

Standard 6 - Communicating for Safety

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

ACTION 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	**Suggestion(s) for Improvement**
The SPH Clinical Governance Plan 2021-2025 and a range of policies/procedures document the governance communication processes within the hospital. Policies/Procedures are available to all via the Healthscope intranet (HiNT). Staff interviewed were able to show how to they could access policies/procedures. The SPH Policy, Forms and Documentation Committee oversees all clinical documentation. The SPH Integrated Risk Register (IRR) lists clinical risks and the mitigation process for managing each risk. Handover processes include a discussion on risks associated with each patient. Incidents are managed in line with Incident Management Policy and clinical risks are reviewed by Medical Advisory Committee (MAC).	

Rating	**Applicable HSF IDs**
Met	All

ACTION 6.2		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes		
Comments		**Suggestion(s) for Improvement**
Assessors observed the bedside Handover process each day of the assessment and noted a high level of compliance with Policies/Procedures There are Patient Care Boards in each bedroom which are update at each handover. The Executive Team also undertake rounds to confirm compliance with Policies/Procedures. ISOBAR is used as a patient identification tool. There is an audit process to evaluate compliance with the communication processes and a review of some of the Audits indicated very high compliance rates. Audit results are included in the Board Key Performance Indicator (KPI) Dashboard Report and through SPH Quality and Safety reporting process to the relevant SPH Committee.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	**Suggestion(s) for Improvement**
The SPH Consumer Partnership Plan 2020-2023 documents bedside handover and patient rounding as a way of ensuring effective communication with patients. The process also affords patients the opportunity to comment on the hospital's communication processes. Patients also can participate in the Patient Experience Survey. The June 2021 Patient Experience Data shows a high level of satisfaction to the questions- 'I was kept informed as much as I wanted about my treatment and care' and – 'I was involved as much as I wanted in making decisions about my care'.	

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		
Observations by assessors at handovers also confirmed that patients asked questions about their care.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	**Suggestion(s) for Improvement**
There are a range of policies/procedures that address patient identification processes. The organisation uses three patient identifiers', and this was observed by assessors at the various bedside handovers during the assessment. The time out process in theatre was also observed by assessors. Safety Huddles occur at every handover. The IRR lists communication risks. Patient Care Plans assessments identify patient risks. Patient Care Boards list a patient's risk/s. Patients going to the onsite Medical Centre or Radiology Service for an appointment are accompanied by a Nurse or an Assistant-in-Nursing who is aware of how to manage any risks or care needs. There is a paging system in place and emergency call buttons throughout the hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.5		
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated		
Comments		**Suggestion(s) for Improvement**
There are policies/procedures that document the 3 standard patient identifier processes, identifiers for mother, father and baby in maternity and the theatre time out process. As stated in other parts of this report, patients were very satisfied with communication from clinical staff. There is an annual audit process to ensure compliance with policies/procedures.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.6		
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care		
Comments		**Suggestion(s) for Improvement**
Part of the pre-admission and admission process requires all patients to confirm why are being admitted and their intended care/service. There is a Pre-admission Check List. Each patient is asked their name and date of birth and what their goals are at each handover. ISOBAR is used throughout the hospital to ensure an effective handover.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	**Suggestion(s) for Improvement**
Handover includes care, planned investigations/tests, risks and any changes in patient care/condition. Each Nursing Unit Manager accompanies the patient's VMO to ensure the Care Plan is current and meets the needs of the patient. VMOs are required to visit their patient at least five days per week and provide a nominated doctor on call to manage their patients for the other two days. Patients are given a Discharge Envelope with post operation /care instructions. Nursing staff contact all patients 24hrs post-discharge.	

Rating	Applicable HSF IDs
Met	All

ACTION 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Comments	**Suggestion(s) for Improvement**
Patient goals are documented in their Comprehensive Care Plan and on their room Care Board. At each handover patients are asked what their goals are. Nursing Discharge documentation is provided to each patient and a copy sent to their GP. Compliance is audited. Medical Records contain an Advance Care Directive where provided by a patient.	

Rating	Applicable HSF IDs
Met	All

ACTION 6.9		
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient		
Comments		**Suggestion(s) for Improvement**
All accredited practitioners are responsible for the care and treatment of their admitted patient and providing quality clinical instructions/notes in the patient's medical record. SPH has established 4 clinical Craft Groups to review care and share decisions on/or about care, changes in clinical practice or clinical pathways, incidents and complaints/complements. Discussions with the Chairman of the MAC and the General Manager indicates that there is good involvement by VMOs. SPH has an Open Disclose process in place and staff and VMOs have been trained in the process. Also see comment in Action.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.10		
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians		
Comments		**Suggestion(s) for Improvement**
PACE Posters (Ryan's Rule) are in each bedroom and throughout the hospital. Assessors were advised of a recent sentinel event and confirmed that the processes aligned with the Open Disclosure Policy-see Action 1.11. The June 2021 Patient Experience Data shows a high level of satisfaction to the questions- 'I was kept informed as much as I wanted about my treatment and care' and – 'I was involved as much as I wanted in making decisions about my care'. Assessors formed the opinion that communication processes at all levels of the organisation were effective.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	**Suggestion(s) for Improvement**
There are a number of policies/procedures that document the processes to be followed by all clinicians in documenting information. The SPH has a paper-based records. Medical Record Audits are regularly performed with the results are discussed at various Committee Meetings. SPH has a high level of compliance with documentation audits.	

Rating	Applicable HSF IDs
Met	All

Standard 7 - Blood Management

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

ACTION 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	**Suggestion(s) for Improvement**
All relevant policies and procedures are in place at SPH for clinicians to safely administer and manage risks associated with blood management. Staff training on specific blood management compliance is high with additional specific education for maternity staff on Post-Partum Haemorrhage (PPH) and nursing staff blood management training.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	**Suggestion(s) for Improvement**
All transfusion and patient consent audits are evident and presented to the relevant working groups.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 7.3		
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making		
Comments		**Suggestion(s) for Improvement**
Patient participation is evidenced with patient brochures and patient education regarding possible risks associated with blood transfusions.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.4		
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks		
Comments		**Suggestion(s) for Improvement**
Documentation provided for Blood management meets all the requirements for the safe use of blood products.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.5		
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record		
Comments		**Suggestion(s) for Improvement**
Clinician documentation regarding the indication for blood transfusion or the chosen alternative is documented in the patient's medical record, including transfusion history and all transfusion details.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.6		
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria		
Comments		**Suggestion(s) for Improvement**
SPH utilises Healthscope suite of audits for blood and blood products to perform and then the results are benchmarked against similar sites for compliance. The Healthscope audits are located on HiNT for staff to access.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.7		
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria		
Comments		**Suggestion(s) for Improvement**
SBP has policies for reporting and managing incidents, including adverse reactions and near misses, relating to use of blood and blood products. All reports from the incident management system (Risk Man) that identify incidents relating to blood and blood products are reviewed and escalated through the Blood Transfusion Committee and National Blood Authority Report.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.8		
The health service organisation participates in haemovigilance activities, in accordance with the national framework		
Comments		**Suggestion(s) for Improvement**
SBP has a suite of audits for blood and blood products to perform and the results are benchmarked against similar sites for compliance. All audits are located on HINT for staff to access Blood Products and include: Transfusion Pathway Audit, Blood Fridge Audit, RiskMan review- Transfusion Risks and Blood Appropriateness Audit		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 7.9		
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer		
Comments		**Suggestion(s) for Improvement**
Monitoring of blood storage and other products is performed daily by QML, minimal wastage occurs as only four bags of Blood is kept on premises. All evidence supported the correct documentation of blood products.		
Rating	**Applicable HSF IDs**	
Met	All	

<table>
<tr><th colspan="2">ACTION 7.10</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><th>Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td>SPH has contingency plans are in place for Massive Transfusion Policy and the escalation process for acquiring blood products in timely fashion.

The recent sentinel event in theatre evidenced the ability to acquire blood products quickly from closest hospital partners, with no apparent delays.</td><td></td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	**Suggestion(s) for Improvement**
SPH has clear recognition and response systems for the deteriorating patient. Policy, exclusion criteria, training and access to ICU services all contribute to a hospital wide system. Track and Trigger Charts are used. SPH staff training includes: Basic Life support (all staff), ALS (specific areas), paediatric ALS, Neonatal resuscitation and obstetric emergency recognition and response. K2 monitoring system is used in Maternity.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 8.2		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems		
Comments		**Suggestion(s) for Improvement**
SPH has a system of reviewing incidents, (via RiskMan reports) rapid response call records and complaints. There are reviews including Root Cause Analysis where appropriate and strategies that close the loop and implement improvements, were noted during assessment. All Healthscope Hospitals provide opportunity for lessons learnt in other sites.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 8.3		
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making		
Comments		**Suggestion(s) for Improvement**
A patient ‘recognition of deterioration’ process called PACE is in place with posters at each bedside and orientation to families and patients during the hospital and ward admission.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 8.4		
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient		
Comments		**Suggestion(s) for Improvement**
Track and Trigger Charts are used. Parameters are reviewed as appropriate and code blue calls are encouraged should any patient fall 'outside of the flags'.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Comments	**Suggestion(s) for Improvement**
Staff have some training in recognising and responding to mental health deterioration. The assessment tool captures the risk for the patient through a thorough pre-admission assessment. Staff record mental health status and potential signs of deterioration for those patients who are identified as higher risk. Patients identified as significant risk of mental health issues may be excluded from admission if clinical assessment identifies the potential / requirement for higher level mental health care. Delirium recognition is reported to be widespread amongst clinical staff and records of comprehensive assessment supports that.	Promote and support a training program for staff to better identify and manage deteriorating mental health.

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	
Acute mental health deterioration and first line management is reported however to not be well-developed staff have requested additional training which is being planned. There are no experienced mental health clinicians on site however access to mental health clinicians is available. Clinicians were able to articulate that they utilise family members to identify changes in behaviours or cognition and use baseline assessment data. The review of all rapid response calls ensures continuous learning and review of the data confirmed a system is in place to support the recognition and response to any deterioration. Observation of Handover during assessment confirmed the awareness by staff and communication of mental health status to mitigate deterioration going unrecognised. SPH meets the requirements of Advisory AS19/01.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.6		
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration		
Comments		**Suggestion(s) for Improvement**
Protocols for recognising deterioration were noted including documentation of physical and mental health observations. Staff are fluent in the process and protocol for calling a rapid response and evidence was seen to support early calls leading to better outcomes. The rapid response process to deterioration is utilised across the facility. Staff were able to report how and when to call and escalation of care is well established. The rapid response team is experienced, responsive and access to higher level care is available. The PACE system is in place for families and staff to activate a review. SPH meets the requirements of Advisory AS19/01.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 8.7		
The health service organisation has processes for patients, carers or families to directly escalate care		
Comments		**Suggestion(s) for Improvement**
SPH has a system called PACE based on Ryan's Rule. There are posters at the bedside and throughout the hospital. Patients and family are advised of the system on admission. Any PACE calls are reviewed by the quality and safety committee.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	**Suggestion(s) for Improvement**
A rapid response team with staff from ICU and Theatres is on call and responds to all areas. Staff are encouraged to call early, and results of the emergency response system demonstrates good patient outcomes based on early recognition.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	**Suggestion(s) for Improvement**
Staff on the rapid response team are ALS and PAL trained. Education is provided to all staff to recognise deterioration.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	**Suggestion(s) for Improvement**
Review of all calls including timeliness of response is undertaken. A report is provided to the Quality, Risk and Consumer Committee. Staff report being supported in the rapid response system. Mock codes are undertaken periodically for adult, paediatric and maternity emergencies. A retrieval pathway is also in place.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	**Suggestion(s) for Improvement**
All shifts have a clinician on site with ALS skills. In maternity, staff also have neonatal resuscitation skills and there is always someone rostered on to respond to a neonatal emergency.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	**Suggestion(s) for Improvement**
Recognising and responding to deteriorating mental health is not as well catered for at SPH. Staff reported this as an area of weakness among most staff. Nurses report however, following up on behaviour changes with family, medical staff and other staff and use appropriate assessment to identify any requirement for additional interventions or transfer. All patients are assessed, and risk assessed pre-admission for mental health and admissions are planned, there is no emergency department.	All nursing staff be supported to undertake additional training in recognising and responding to deterioration in mental health.

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	
Should a patient require acute mental health care there are links with the public sector close by and the VMO, and intensivist if required, would facilitate transfer of escalation of care. SPH meets the requirements of Advisory AS19/01.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	**Suggestion(s) for Improvement**
Rapid response and transfer to ICU services is available on site 24/7. Patients are able to be stabilised and ventilated if necessary and transfer is available via Queensland Ambulance Service to a tertiary service.	

Rating	Applicable HSF IDs
Met	All

Org Name : Sunnybank Private Hospital
Org Code : 721758

Recommendations from Previous Assessment

Standard 4

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				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
Met	Sunnybank Private Hospital	**Recommendation EN OWS 0916.4.1.1** Introduce a monitoring mechanism to ensure ongoing compliance with medication safety policy and ANZCA guidelines in the Operating Suite in regard to this practice. **Risk Rating: Low** **Risk Comment:**	Local Quality action plan in place to address non-compliance and actions to improve Review and update of local policy and procedure guidelines referencing ANZCA Guidelines Communication to VMO's via electronic communication and through MAC on Compliance results against ANZCA Guidelines Audit schedule in place to monitor compliance and results shared with relevant craft groups Follow up with non-compliant VMOs by Executive Team Action plan and audit results will be presented during onsite survey **Completion Due By:** 2021 **Responsibility:**	**Recommendation Closed:** Yes The recommendation is closed. A local action plan was put in place following the last assessment. There are now substantial processes in place to mitigate unsafe medication management in theatre. There is daily monitoring, auditing and recording of medication safety. Trended data was reviewed as was the practice. All restricted drugs, including those that may be the subject of abuse are appropriately signed out and administered per patient. All processes are now compliant with ANZCA and ACSQHC Standard 4.

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				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
			Organisation Completed: Yes	