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

Parkwynd Private Hospital

Adelaide, SA

Organisation Code: 32 01 72

Survey Date: 28-29 November 2017

ACHS Accreditation Status: **ACCREDITED**

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 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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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve.

Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on-site survey.

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Survey Report

Survey Overview

Parkwynd Private Hospital (PPH) is a progressive acute medical and surgical hospital led by a dedicated and committed team to ensure care and services are delivered safely.

The surveyors noted the active participation of managers and staff during the survey. The Consumer Consultant (CC) is very engaged and her contribution to the hospitals quality improvements was clearly evident and extremely valued. The surveyors appreciated the information provided prior to the survey and at the time of the survey. Evidence was available to support the hospital's self-ratings of Satisfactorily Met (SM) in all National Safety and Quality Health Service (NSQHS) Standards Core Actions.

Recommendations for Standard 2 (actions 2.2.1 and 2.6.2) have been met and closed.

Significant progress has been achieved in relation to the developmental actions and the two prescribed actions 3.10.1 and 9.6.1, Training in Aseptic Technique and Basic Life Support.

Quality and Safety Action Plans, staff education and training as well as competency assessments are also in place to address other areas for improvement. Review and evaluation of key indicators and projects is occurring and remains ongoing.

The surveyors were particularly impressed with a quality improvement project undertaken this year (refer to surveyor comments action 6.2.1) and felt that this initiative was worthy of a Met with Merit rating. The activity related to Clinical Handover Processes, whereby a review was conducted regarding the cost, design and information displayed on whiteboards in patients' rooms.

The survey team also wish to acknowledge a special initiative which clearly combined Partnering with Consumers and Cultural Diversity. This project stemmed from a visit by one of PPH's ENT surgeons to the Nunyara Aboriginal Health Service in Whyalla South Australia to assess children's hearing. Funding was made available as part of the Commonwealth's Indigenous Australian's Health Program, "Healthy Ears". When the management and staff became aware of the project, there was great enthusiasm and motivation to be engaged, and as a result PPH became a partner in the project providing the operating theatre and hospital accommodation as well as their clinical expertise. Information to the families and children was vital and included education and a visit to the hospital, documentation regarding pre and postoperative care, as well as details and maps of Adelaide's CBD and available accommodation for immediate and extended family members and of course their responsibilities for the child's care. This was in collaboration with the Nunyara Aboriginal Health Service management and staff. As a result, eight Aboriginal children had their surgery performed at PPH with outstanding results. To quote in the recent Nunyara Newsletter:

> *"A special moment took place after one of our young clients had received his surgery. He was walking along Rundle Mall with his mum and he put his hands over his ears and said "mummy, very loud". That little one had not heard the everyday sounds of life and the environment around him that we take for granted".*

The surveyors do hope that the wonderful outcomes from this project will be acknowledged and continued in the future.

Overall, PPH has a comprehensive clinical and corporate governance structure with robust systems to manage quality and risk. The information is well documented and provides evidence of indicators and outcomes to measure and improve performance.

Clinical practice is evidence-based and staff clearly understand their responsibilities. There are mechanisms in place to support the early identification, intervention and management of patients at increased risk of harm with relevant and appropriate systems to escalate the level of care in the event of unexpected deterioration.

The patient clinical record is well integrated and appropriate to good patient care.

Credentialing and scope of practice is managed in accordance with HSO policies and by-laws.

Performance and skills management is well done - with appropriate systems in place to support, monitor and evaluate performance across all disciplines.

Staff education and training in respect of patient safety and quality is ongoing.

The system for managing incidents and complaints is well embedded and effectively managed across the hospital. Open disclosure policies and processes are in place and the clinical workforce has been trained.

Patients' Rights and Responsibilities are well respected and included in care planning.

The survey team noted an improved level of compliance with Partnering with Consumers and was impressed by the by the commitment of the Consumer Consultant representative and the many enhancements and improvements she has generated to improve patient safety and comfort within the hospital as the consumer advocate.

The clinical safety of services related to infection prevention and control (IP&C), is exceptionally well managed in an environment that is aware of managing risks and improving performance. A well-managed IP&C system was evident with the recent gap analysis compliant with ADS/NZ 4187: 2014 being completed and subsequent action implemented.

The hospital is impeccably clean and tidy and the low infection rate is testament to the efficacy of the systems.

There are established processes in place to manage medication safety. Documentation of patient information, continuity of medication management and the reconciliation of medicines are audited regularly.

With regard to patient identification, blood administration and pressure injury prevention it was evident that practices implemented by PPH, meet the necessary intent of the standards with significant improvements resulting in nil adverse events over the past three to five years.

Clinical Handover is outstanding with good local processes developed in collaboration with clinicians, patient and carers. The improvement to the information on the whiteboard is very impressive.

Skilled, caring and responsive staff are extremely well educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient's health status.

Preventing falls and harm from falls is reported and managed diligently with good patient outcomes noted.

PPH has demonstrated over recent accreditation cycles a strong commitment to the Standards and is to be commended on their good work and achievements in improving care and services. Further comments and suggestions for improvement have been included in the Standard Summaries.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

PPH has a well-defined corporate and clinical governance structure appropriate for the range of services provided by this hospital. Clinical and support staff involvement in safety, quality and risk management is clearly demonstrated.

There is a range of Healthscope Office (HSO) corporate and cluster policies and procedures in place, along with local policies as deemed applicable. There is a document control system whereby all policies are kept up-to-date and are readily available to all staff. Legislative changes are monitored at corporate level and the hospital is informed of any changes that may be required. There is a strategic plan for 2017/2018 and a Clinical Governance Framework for the period 2017/2018. Safety and quality forms the basis in decision making and this is evident in the strategic and business plans for the hospital. The hospital's organisation and committee structure supports the overall governance of PPH.

The Medical Advisory Committee (MAC) is actively involved in all aspects of clinical care. The information provided to the members, particularly the comprehensive clinical indicator set is well documented and reflects the hospitals clinical performance. For example, credentialing, infection control, morbidity and mortality and adverse events are standard agenda items. In addition to ACHS Quality Indicators, the hospital participates in benchmarking activities with similar peer group hospitals within the HSO group. PPH results are in the top rankings which is to be congratulated.

Staff are aware of their roles and responsibilities in all aspects of quality and safety. Position descriptions are in place and annual performance reviews conducted.

Staff orientation is provided at the commencement of employment. The mandatory training schedule is comprehensive and incorporates eLearning packages (ELMO), face-to-face education and training, as well as competencies applicable to the specific disciplines. The monitoring and diligent management of the education program is highly impressive 100% compliance has been obtained in all the mandatory topics, a significant achievement.

The survey team also noted the wide range of topics on the mandatory training agenda and suggests that the hospital undertake a risk rating of the topics with a view of reducing the list to the essential ones only.

The risk register is managed by the hospital and clearly identifies clinical safety, financial and occupational health and safety risks. The register is monitored and reviewed regularly. Each identified risk has a risk rating and linked to a mitigation strategy. The hospitals organisational wide quality improvement system is led by the Quality and Risk Committee. The extensive suite of indicators are well documented and reported and discussed at the committee and department level. The committee also reviews the quality action plans of the hospital.

Clinical practice

Clinical services are governed by a raft of best practice clinical guidelines. Compliance is monitored through rigorous reporting of adverse events, near misses, results from audits and patient complaints and feedback. There are validated risk assessment tools used for assessing all patients on admission. Those deemed “high-risk” or at risk of harm are then subject to further screening and assessment.

Benchmarking occurs at peer group level and monitored by the cluster committees. Serious breaches are reported to HSO.

There are clear exclusion criteria and guidelines that outline the procedures that can be performed safely and within the clinical capabilities of the hospital. If, however, there is an unexpected deterioration in a patient’s health status there are well qualified medical and nursing staff available to assist.

Emergency support is provided by the ambulance service and there are good relationships established with the Royal Adelaide if the need arises.

The patient medical records well collated and managed in accordance with relevant standards and guidelines. Colour coded dividers have been introduced and this has certainly made it easier for staff to find information within the record. New medical record chart holders have also been introduced in every room; this has improved the timely access to the medical record by the clinical staff.

Clinical coding is of high priority and is a project across all HSO facilities and documentation audits are conducted annually to address compliance. It has been suggested that the hospital undertake an internal audit in relation to the use of abbreviations such as Left and Right to ensure documentation is meeting the policy.

Performance and skills management

All Visiting Medical Officers (VMOs) appointed to the hospital are subject to the HSO credentialing process and a defining of their specific scope of clinical practice. The credentialing procedure is clearly outlined in Schedule 5 in the HSO by-laws. The new e-Gov credentialing system enables the medical staff and allied health professionals the ability to go online and register their application and or re-credentialing requirements. HSO and the hospital are now able to review applications remotely. This system overtime will eliminate the need for a paper based system to be maintained. New appointments and re-appointments are reviewed by the MAC along with new procedures.

A VMO scope of practice audit in 2016/2017 achieved 100% compliance.

Information on the scope of practice is also made available to key members of the clinical staff and Operating Theatre Manager.

However, the surveyors did note the substantial number of VMOs on the current list and have suggested that the hospital undertake a review of the number of VMOs that are actively using the hospital services versus the VMOs who rarely visit. HSO and the hospital may then consider a timeframe by which the appointment is no longer valid.

Members of the nursing and allied health staff have their scope of practice defined in their position descriptions or contracts. Staff appraisals include competencies and are reviewed annually.

Incident and complaints management

Incidents and complaints are reported within the hospital and recorded on RiskMan. Information is provided to the management and staff, the MAC and to HSO. Significant results or events are also published on Shared Learnings which is a very constructive way of disseminating outcomes and lessons learnt to the staff. PPH has very few complaints but has received numerous compliments from very satisfied patients.

An open disclosure policy is in place. If an event occurs that requires such disclosure, support from HSO is readily available to assist the management and staff.

Patient Rights and Engagement

The National Charter of Patient Rights and Responsibilities is well displayed throughout the hospital. It is included in the patients' admission pack and features on the hospitals new DVD presentation which is a great initiative.

Patients are actively involved in their care and consent for procedures are well explained and documented. Consent processes include clinical consent and informed financial consent. Interpreter services are available if the need arises. Feedback is also gained from the patient experience and patient-centred surveys.

PPH is a short stay surgical hospital, LOS of three days with a very busy Day Surgery Unit. If an advance care directive is warranted, this is referred back to the patient’s general practitioner, however, it is a question identified on the patient history. There is also a policy and alert system relating to NFR orders if applicable.

Privacy and confidentiality is managed well and all staff are aware of their roles and responsibilities.

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

PPH was able to clearly demonstrate consumer involvement within the hospital in service planning. The CC is the primary consumer representative and participates, provides consultation and advice to the hospital through a range of governance, strategic, operational and management committees. It was also evident the CC networks across departments throughout the hospital and plays a significant role and contribution at all levels within the hospital. The level of engagement was also demonstrated through Committee minutes, decision making processes and engagement with the accreditation was impressive.

Policies that guide and support consumer involvement within the hospital include but not limited to: Consumer Approved Publications, Patient Satisfaction Surveys, Corporate and Parkwynd Safety and Quality Plan includes consumer involvement, Healthscope Corporate Consumer Advisory Committee and the Consumer Participation Cluster.

Corporate Consumer Forums are held in different capital cities yearly and SA held this year's forum in May 2017 which was attended by PPH CC, QRM and GM/DON. Other CC involvement included input into the new handrails installed throughout the hospital, updating of the patient white boards located in each room, introduction of note pad/pencil for patient to use, input into the current upgrading of bathrooms including colours, towel rails and many other improvements too numerous to mention in this report.

Consumer partnership in designing care

PPH engages in a range of mechanisms that support and facilitate consultation and feedback in the design and redesign of the hospital.

A Patient Centred Care 'experience' survey is conducted annually and evaluation of results is completed by staff including the CC. To ensure patient-centred care is a major component of the hospital's 'core business', consumer feedback is provided in a variety of ways and includes: satisfaction surveys, the CC representation on various committees, development of Parkwynd's DVD information loop around the ten National Standards.

The CC has also been involved in reviewing information and presentation of Parkwynd, MyHealthscope website with PPH management which was revised and enhanced in July 2017. The redesign of the Day Surgery and in particular the 'Kids Corner' included input from the CC and the popularity of the area has been evidenced in feedback from parents and some of the older children themselves. Another initiative implemented by CC and nursing to assist developing a rapport with children prior to their surgery, are the KIDS activity bags which contain ' activity colouring book, coloured pencils, reading material and a disposable children's bear and disposable drinking cups.

The MyHealthscope website - assessable via Parkwynd website, now has quality information which is updated annually by the Healthscope Quality Department, and includes Hand Hygiene compliance, Infection rates, Patient Falls, Pressure Injuries, Unplanned Re-Admissions and any Blood transfusion events. This data is displayed on hospital noticeboards in Day Surgery waiting lounge, ward entrance and also VMO noticeboard. The CC as a member of the QRC is aware of all these reports and has provided input and suggestions accordingly.

Consumer partnership in service measurement and evaluation

There exists within the hospital mechanisms to inform consumers and carers on relevant safety and quality performance. The CC is a member on the QRC and management committees and evidence provided fully reflects the commitment of the CC involvement and participation in the planning, implementation and evaluation of consumer feedback data. Thus, demonstrating their commitment to ensuring the consumer/carer voice is listened to and actioned to improve quality of services and service delivery across the hospital.

PPH also demonstrates some excellent results at both the micro and macro level that encompasses and embeds the full quality cycle, from the beginning in identification of issues to implementation and further evaluation of the effectiveness of the quality improvement process.

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

PPH was able to demonstrate well developed systems in place to ensure their Infection Prevention and Surveillance program meets all the requirements of Standard 3. Strategies exist to prevent infection of patients within the hospital, to manage infection/surveillance effectively if/when they do occur and to minimise the consequences.

These systems were underpinned by evidence-based Healthscope Corporate Policies as well as PPH local policies which include: Peripheral Intravascular Cannulation and IV lines, Blood & Body Fluid Exposure, Safe Operating Procedures (SOPS), Cleaning Policies and Infection Control Resource Folder developed by staff.

PPH local policies are developed and reviewed by the Medical Advisory Committee (MAC) and Quality and Risk Committee (QRC) members for approval.

Revision of policies and procedures is monitored by PPH Local Document Control (LDC) Tracking Register. PPH has a level 2 subscription to Healthcare Infection Control Management Resources (HICMR) which entitles them to access HICMR policy and procedures manual both hard copy and electronic for audit tools, education material, brochures and ongoing communication for advice. This subscription to HICMR also provides a service to PPH for a facility wide evaluation review every two years and provides Action Plans to be completed by the Infection Control Coordinator (ICC).

The QRC has responsibility for the development of risk based local audit tools and annual audit schedule which also includes both Healthscope Operations (HSO) and HICMR audit tools as required. There is a system in place to review all clinical incidents both formal and informal and at times may indicate the need for a review of policy or a quality activity. Where systematic issues are identified they will be transitioned to the operational risk register and risk rated.

Infection prevention and control strategies

There has been a concerted effort and commitment to the improvement of hand hygiene (HH) throughout PPH. The Q/R Committee are to be congratulated on their efforts to achieve some outstanding results, not only the overall percentages but also individual departments. PPH hand hygiene results are higher than the national targets, with strategies in place to raise any areas with identified lower levels. The Hand Hygiene Australia (HHA) 5 moments approach has been undertaken across the hospital and audit results reported to HHA. PPH compliance rate for 2016/2017 hand hygiene was 86% and a marked improvement of compliance by the VMOs was noted by the survey team. The use of Hand Gel is actively promoted, readily available and used by both staff consumers and visitors across the hospital.

MyHealthscope website - PPH is transparent in public reporting of hand hygiene compliance data since 2013. As a result of additional training, PPH has a Gold Standard Auditor on staff with a certificate endorsed from HHA. The 5 moments of hand hygiene posters were obvious throughout the hospital particularly in the clinical areas including Day Surgery and waiting areas. Education, training and annual competency assessments are provided for all clinical staff and this education includes appropriate clinical staff trained in performing aseptic technique and invasive devices procedures.

Policies and procedures define and identify compliance with the National Guidelines for immunisation and occupational health and safety and cover pre-employment screening for all hospital staff. There is a process in place for the management of occupational exposure and non-vaccinated staff. Flu vaccination uptake continues to increase each year and 2017 (to date) 65% of staff have been vaccinated, whilst Hep B 100% compliance for years 2016 and 2017.

The Infection Control Coordinator (ICC) manages any body fluid exposure and ensures the appropriate documentation is completed and reported to the appropriate authority.

Invasive devices are strictly monitored and guidelines and instructions are available to staff in their specific use. There is a comprehensive process for the training of clinical staff in the use of these devices and formalised competency based education and training for assessments annually.

Aseptic technique has also seen some impressive results and at the time of the survey the compliance rate was 97% and an action plan in place to address the small number of non-compliant to undertake education and training.

Managing patients with infections or colonisations

Personal Protective Equipment (PPE) is available and used with clear guidelines for implementing standard or transmission based precautions. Staff actively isolate patients with diagnosed or suspected infections. Patients with infections are provided support and updates on their condition during clinical handover and VMO visits. An active surveillance program is well established and a system of alerts in place to support accommodation of patients with known multi resistant organisms (MRO).

The survey team congratulates PPH on the excellent initiative in May 2016, to install three PPE Stations strategically located in the main corridor of the clinical wing. This came about as quality activity by staff and CC input and has proved to be highly successful.

Antimicrobial stewardship

PPH Antimicrobial Stewardship Program effectively meets the needs of the hospital and is supported by the services of a part-time clinical pharmacist who reviews medication management and makes recommendations to VMOs as identified and followed up by the NUM/ICC. Auditing of antibiotic usage is completed in accordance to the audit schedule and results are a standing agenda item on both the MAC and QRC. The South Australian Advisory Group on Antibiotic Resistance (SAAGAR) guidelines are used for several surgical specialities which include Orthopaedic, ENT, Oral Surgery and General Surgery and are monitored by the ICC. e-Therapeutic Guidelines are assessable to staff and hard copy Antibiotic Guidelines are also available. The pharmacist also completes twice weekly surveillance on antibiotic prescribing and the Healthscope VMO Medication Action Form is used by the pharmacist and staff which alerts the VMO to any actions required with prescribing in the patient's medication chart. Any issues related to the AMS program are tabled at both MAC and QRC.

Cleaning, disinfection and sterilisation

It was clearly evident under the direction of the Integrated Services Manager, Catering and Cleaning services demonstrated a high level of compliance with policies, procedures, cleaning practices and waste disposal services. The surveyors congratulate the manager and his staff for the exceptional cleanliness of the hospital and its buildings.

Comprehensive education, work instructions and cleaning schedules were evident and cleaning products meet legislative compliance.

The disinfection and sterilisation of reusable instruments and equipment is currently undertaking some significant changes in order to meet compliance with the recent changes in AS/AZ 4187: 14.

Healthcare Infection Control Management resources (HICMR) in 2016 audited the sterilising services against the revised AS/NZS 4187 and PPH has completed a gap analysis to determine the current level of compliance with AS/ANZ 4187 and has documented the findings. Significant progress has been made to minimise any breaches in regard to cross contamination.

An external service - Steriliser Validation Australia were engaged by PPH to assist with the gap analysis. As a result of the extensive review, a documented and detailed implementation and action plan has been developed and implemented with specified timeframes to enable full implementation of the process over a five-year period. A business case to re-design the CSSD is underway.

There is a manual instrument tracking system in place which will be replaced by an automatic system as part of the Sterilising Services Action Plan currently being undertaken.

Communicating with patients and carers

There has been a great of commitment by PPH to engage with consumers and carers. The Consumer Consultant has been instrumental in supporting many of the changes suggested by consumers to meet their needs. Patient and carers are made aware of risks associated with infection control and information brochures have been reviewed with CC input and suggestions made for improvement. As previously mentioned. the Consumer DVD based around the ten National Standards for patient information is an excellent innovation and is widely used and accepted by both staff and consumers of the service. MyHealthscope website provides valuable information for consumer with respect to infection control prevention and also PPH performance data.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

In compliance with Transitional Arrangements for Hand Hygiene (HH), PPH has a well-documented program in place and current HH results are higher than National targets with strategies in place to raise any areas with identified lower levels of compliance or areas of drop off. Education and competency training is provided to all clinical staff and this includes staff who perform aseptic technique and invasive procedures with demonstrated high levels of compliance by audit and documented attendance records.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

Healthcare Infection Control Management Resources (HICMR) in 2016 audited the sterilising services against the revised AS/NZS 4187:2014 and PPH has completed a gap analysis to determine the current level of compliance with AS/NZS 4187:2014 and has documented the findings.

An external service, Steriliser Validation Australia, was engaged by PPH to assist with the gap analysis. As a result of the extensive review, a documented and detailed implementation and action plan has been developed with specified timeframes to enable full implementation of the process over a five-year period.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Medication Safety policies, procedures and protocols are in place and in accordance with National and Jurisdictional Legislative requirements. Prescribing, dispensing, administration, storage and supply are all managed well.

Medication errors and adverse events are reported on RiskMan. The medication management system is regularly monitored by a range of activities and audits including the National Inpatient Medication Chart (NIMC) audit, the Medication Safety Self-Assessment (MSSA) and Ward Drug Audits.

Medication incidents are discussed at the Quality and Risk Committee, MAC and at Cluster level. PPH has continued to maintained overtime a very low rate of medication errors. Staff are required to use an internally developed reflective practice tool if they are involved in any medication error incidents.

Hospital Pharmacy Services (HPS) Clinical Pharmacist is also actively involved in all aspects of medication safety.

Position descriptions include medication responsibilities and provide guidance on scope of clinical practice. A specific policy for medication endorsed enrolled nurses inclusive of IV medication administration is in place. Education is of paramount importance and comprehensively managed. A mandatory education module specific to medication management for registered and enrolled nurses ‘Med Safe’ achieved 100% which is to be congratulated.

Documentation of patient information

A best possible medication history is obtained from all patients at the time of admission. A Medication Management Plan is used for all medical and joint replacement patients. The PPH Medication Reconciliation Flow Chart and Medication Management Plan include the medication reconciliation process on admission and transfer and at the time of discharge.

Medication allergies and adverse drug reactions are recorded in the patient’s medical record and at the bedside. This is routinely audited and evaluated. As part of the admission, patients are required to complete a Patient Health History which also incorporates questions specific to medication management.

The Clinical Pharmacist is involved in this process which is well established and effective.

Patients who stay overnight and Day Surgery patients also have their medications documented on the NIMC.

Medication management processes

There are a range of decision support tools and resources to support the clinical workforce at the point of care such as ‘eMIMs’ and eTherapeutic Guidelines (eTG).

Internal monitoring systems and regular audits are conducted to review the secure storage and safe distribution of medicines throughout the hospital. The ward and theatre drug rooms were extremely well organised. “High Risk”, Look-a-like-Sound-a-like medications, DDAs and injectables were clearly labelled. The stainless-steel shelving provided is impressive.

Receipt and disposal of unwanted and expired medications is managed by HPS throughout all clinical areas.

Temperature sensitive medications are monitored daily. A new medication fridge has been installed in theatre and the ward should have theirs delivered next month.

Continuity of medication management

The Clinical Pharmacist is actively engaged with patient’s medication management. Patient’s current medications are recorded at the time of admission and documented on the NIMC and or Medication Management Plan by the clinical staff in consultation with the patient.

The Clinical Pharmacist provides medication profiles and education to patients if new medications have been prescribed or if medications have changed.

Medication reconciliation occurs at the time of discharge which is completed by the Clinical Pharmacist. A new Handover of Care Checklist has been introduced and includes a section for discharge medications.

A nursing discharge summary created through webPAS is a secondary source of relevant medication information that is provided to the receiving clinician during clinical handover and upon discharge.

Communicating with Patients and Carers

Patients, families and carers have the opportunity to discuss medications at any time. Purposeful rounding and bedside handover also provides the patient with further opportunities if they have concerns.

Warfarin and Patient Controlled Analgesia information booklets are provided and consumer medication information leaflets are available in the ward and day surgery and are given to patients on discharge.

All staff have access to HPS Pharmacy to seek advice and information if required.

The hospital’s in-house DVD provides patients with information about medications and their role in medication safety. Feedback from patients is very positive.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Parkwynd Private Hospital
Orgcode : 320172

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Patient identification and procedure matching is unambiguous and reflects the specific intent of this Standard. A comprehensive hospital system which includes staff responsibilities allows for the reliable identification of patients at each treatment episode.

Local policy for patient identification includes but not limited to: patient identification, correct site, inter hospital transfer and clinical handover. Compliance with policy is monitored through audits mandated by the hospital. Audits for correct patient identification bands for the past three years demonstrated 100% compliance.

Patient identification meet the National Specification Standard. PPH uses four patient identifiers instead of the suggested three which is an HSO decision. The four are used at the time of admission or registration to allow for the matching of a patient's identity to care, therapy or services, clinical handover, patient transfer or discharge. The corporate decision to include four patient identifiers is justified because patients who have diagnostics prior to admission do not have UR numbers on reports. The risk register includes controls for the reduction of patient ID errors and ongoing reviews ensure controls remain effective.

Processes to transfer care

ISOBAR is used for all transfers of care including handover and discharge and incorporates patient identification. Handover is now a well-established practice in the clinical setting and there is an explicit understanding of staff regarding the importance of patient identification and procedure matching. In the operating theatres, this process is monitored and audited daily, 'time out' processes for all interventional procedures is rigorously monitored to ensure appropriate patient identification is undertaken. PPH also allows parents of children into theatre and be waiting in Recovery Room for the child following the procedure.

Processes to match patients and their care

There has been an extensive amount of work undertaken in relation to developing protocols for matching patients with their prescribed care. All patient identification practices witnessed during the survey were undertaken with care.

Patient ID is a standing agenda item at Quality and Risk meetings and any incident actioned as required. Peri-Op staff receive education via eLearning and includes correct patient, correct site, correct procedure.

eLearning compliance for correct patient, site and procedure for 2016/2017 was 100%.

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation : Parkwynd Private Hospital
Orgcode : 320172

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical handover is done well. There is a raft of handover tools and checklists in place underpinned by comprehensive policies, procedures and audits. Clinical handover incidents are reported and monitored at the local level and against HSO indicators, for example, Nursing Discharge Summary within 48 hours is over 85%.

Information about incidents relating to the handover process is shared with other similar hospitals to assist in ensuring improvements are applied to the procedure.

It was noted that clinical handover incidents are rare at PPH. The results achieved are testament to the staff's vigilance in this regard.

Clinical handover processes

At every point of care there are systematic inter-departmental handover processes, checklists and discharge criteria. The ISOBAR tool has been adopted as the standard format for clinical handover.

A printed sheet of patient information is available to staff members involved in the handover. At ward level, handovers include an initial meeting of the ward nursing staff followed by a handover by staff members caring for specific patients. Bedside handover is conducted in the afternoon where each patient's treatment and care plan is discussed.

Allied health professionals and VMOs are clearly involved in handover. Progress note entries are well documented allowing any clinician at any time to view the progress of the patient's care. There are good relationships with Radiology and Pathology providers to ensure results are available in a timely manner.

Recent improvements include a more comprehensive format of information on the whiteboards in each patient's room.

Patient and carer involvement in clinical handover

Active involvement of patients, families and carers was evident. There is a wealth of information on admission about handovers explaining the role of the clinician and the role the patients can play in the handovers as they occur.

Patients are periodically asked for feedback regarding, participation in their care, staff identification and communication. PPH has achieved a rating of over 90%.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Action 6.2.1 Core

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

Surveyor Comment:

A review was conducted regarding the cost, design and information displayed on whiteboards in patients' rooms. Feedback from staff indicated that the existing whiteboards did not provide enough information, and whilst there were basic headings set out on the whiteboard, staff were still required to hand write information on the board. In some cases, the writing was difficult to read by other healthcare professionals. Also, when the board was cleaned during and after the patients stay the heading labels were either peeling off or would often need replacing.

To address this problem the staff and the Consumer Consultant designed a paper based template (housed in a frame) which included a standard suite of important information such as, falls and pressure injury alerts, treatment plans, allied health visits, discharge information and more importantly a section that explained to patients how to alert the staff if they felt unwell. Tick boxes were placed beside each specific care need.

A clear plastic cover over the top of the template securely houses the information. Staff are able to write on the plastic cover using a whiteboard marker. The tick or written information can be updated and erased easily on the patient's discharge, hence the paper-based template does not have to be replaced. The display and presentation of the information is clear, systematic in design, clean and cost effective.

The re-designed boards have been in place for approximately 12 months and evaluation and feedback from both staff and patients has been extremely positive.

A quote from a patient in September:

"Clinical handover is done well and the communication board is one of the best I have seen".

Surveyor's Recommendation:

No recommendation

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : Parkwynd Private Hospital
Orgcode : 320172

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Healthscope policies for blood and blood products are in use to support safe transfusion practices and the management, storage and transport of blood products. The Quality and Risk Committee and MAC oversee safe management of blood and blood products. The Healthscope Blood Transfusion / Pathology Committee provides direction and advice regarding policy development to facilitate consistency of policies across Healthscope facilities. Several pathology services provide blood and blood products to PPH. Nursing staff complete the eLearning Transfusion Management Program annually, monitored by educators, components include; Clinical Transfusion practice, Collecting Blood Specimens, and Transporting Blood and Blood products.

Risks are regularly assessed for patient safety and include accurate patient identification for each step of a blood transfusion procedure from pre-admission, collection, labelling of specimens through to bedside verification and administering of the transfusion. There is an alert system for any known reactions or special considerations and this is documented in the medical record. There have been no incidents reported involving blood/blood products in the past six years.

Systems are established for monitoring of compliance with policies, procedures and protocols established and include scheduling of internal audits and review of indicator data. A suite of KPIs were sighted and included incidents, adverse events and wastage. There is a process in place for reporting of transfusion related adverse event to the pathology services provider and the Therapeutic Goods Administrator. Risks associated with a blood transfusion management and risk mitigation actions are entered into the risk register which is reviewed regularly.

Documenting patient information

Evidence was sighted that demonstrated appropriate documentation of the patient's history at the time of admission this includes previous blood transfusions and any adverse events during the transfusion process. Blood transfusion audits monitor clinical information and documentation in the Medical Record including reason for transfusion, HB levels pre and post transfusion, clinical presentation and signs and symptoms indicating reason for transfusion. Audit results over the past five years have shown 100% compliance with documentation and administration of blood transfusions which include: transfusion given within four hours, two checking signatures and pre and post observations completed.

Consent is obtained prior to each transfusion in consultation with the VMO and a transfusion will not be commenced unless the nursing staff have sighted the written consent prior to commencement. Compliance with consent is 100% and there have been no adverse incidents with respect to consent within the past five years.

All patients who have a blood transfusion at PPH have their records audited by the PPH Blood Safety Champion annually and completed results are sent to the 'Transfusion Nurse Consultant' at BloodSafe-Australian Red Cross Blood Services who send a report to the QRC.

Managing blood and blood product safety

There is a system and processes in place for safe management, transport and storage of blood and blood products and the monitoring of wastage. As a result of a quality activity, a maximum of two emergency blood packs are ordered, rotated and returned to the Blood Centre prior to expiry date for use elsewhere. A blood register is located in the theatre complex to monitor blood movements in and out of the specific blood fridge, which is monitored for temperature control and recorded daily. Audits on the maintenance of the fridge confirm checking and documentation as per PPH guidelines is undertaken and an audit of the use of policies, work practices, guidelines for the receipt, transportation, handling and storage and results indicating 100% compliance.

Communicating with patients and carers

Patient information with respect to blood transfusion is available in a variety of ways including the website, factsheet and BloodSafe Consumer Fact Sheet. Information is also available on the patient DVD (previously discussed) which has had Consumer Consultant input and the SA Health pamphlet 'Receiving a Blood Transfusion: Important Information' is provided to patients by the VMO or Nurse at the time of consent. Verbal discussion is also undertaken by the VMO and Nursing staff to ensure the patient fully understand the reason and process for a blood transfusion and will include there understanding of providing written consent.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Healthscope Pressure Injury Management Policy 8.05, procedures and protocols were sighted and comply with Pan Pacific Guidelines for Pressure Injuries Management. The policy is supported by evidence-based procedures which include; wound management protocols, skin care, assessment tool, pressure injury management plan, consumables and equipment and the Admission Assessment which contains pressure injury screening questions. HSO's modified Waterlow Pressure Injury Risk Assessment and Management Plan is used in the event of a suspected pressure injury. The plan includes; pain management, wound management, pressure injury devices, and other protective consumables and gel packs.

The policy also outlines that any pressure injury or deterioration in a patient's condition are considered as incidents and recorded in RiskMan from which reports can be generated with information about a patient admitted with a pressure injury or acquired since admission. RiskMan extension questions provides additional data about the patient's current pressure injury status and the interventions in place.

Corporate Quality KPI data includes quarterly measuring and reporting of Hospital Wide Clinical Indicator 3.1 against KPI <0.02% and results for the past three years show PPH as being 0.00%. The surveyors congratulate the staff on this excellent achievement.

Preventing pressure injuries

The pre-admission assessment process which is completed on all patients over the age of 14 years, quickly identifies those patients at risk of a pressure injury. An established audit program is in place to identify the effectiveness of the assessment tools in use and if current management plans in place meet the needs of patients who may be of a high risk. It was evident that procedures and protocols in place for prevention of pressure injury throughout the hospital are of a very high standard.

Nursing staff are diligent and focused to ensure pressure injury prevention remains a high priority in regard to patient-centred care.

Managing pressure injuries

Evidence-based systems are in place in the event a pressure injury should occur. The improved documentation processes have also included input from the Clinical Consultant and results from audit and surveys have also led to improvements in work practices and clinical care.

Education and training has played a significant part in pressure injury prevention, and management plans are congruent with best practice principles.

Staff have access to the guidelines of the 'Australian Wound Management Association' 2012 and this provides information to guide staff about pressure injury management including, treatments, dressings and a selection of equipment. PPH obtained permission from "Healthcare Improvement Scotland" to use a comprehensive Wound Management Chart which captures and documents the status of the wound, goals of the management plan and confirmation of reviews of the wound being undertaken.

Communicating with patients and carers

Evidence and discussions with staff and senior management during the survey clearly indicated that PPH has a clear mandate to involve patients and carers in the prevention and management of pressure injures. There was a wealth of information provided to patients and carers including the DVD video, as well as fact sheets and brochures.

The surveyors must again congratulate the staff at PPH on the last three years whereby they have not recorded a pressure injury and this therefore would indicate the strategies and systems in place are sustainable in the systematic approach to preventing and managing pressure injuries.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The hospital is to be congratulated on their management of the deteriorating patient. Significant work has been conducted by the ward; day surgery and theatre to ensure robust systems are in place to recognise the deteriorating patient. Evidence-based tools are used which allows evaluation and auditing to be measured and compared in a systematic way.

Recognising clinical deterioration and escalating care

Track and trigger adult and paediatric observation charts and the ISOBAR communication tool is used to report clinical deterioration.

Clinical deterioration events are registered on RiskMan and escalated to senior management if the need arises. Staff feedback is positive and they felt confident when making a call.

Mortality and morbidity reviews are presented at the MAC and any recommendations are actioned accordingly.

Responding to clinical deterioration

Policies and procedures are well established and support the management of the deteriorating patient.

There has been a significant focus on education and training for all staff commencing at orientation and ongoing.

From a recent Coroners Report it was deemed mandatory that all clinical staff have refresher training on pulse oximetry and O2 saturation. In 2016/2017 ELMO training was provided on this topic. PPH clinical staff achieved 100% compliance.

Emergency trolleys are well equipped and checked on a regular basis. A new call bell system has been installed to improve emergency code responses by the patient.

MET call flowcharts are in place in all clinical units. MET calls and up transfers are monitored and reviewed when the need arises. Clinical staff are aware of their responsibilities in regard to assessment and code blue.

Out of 5207 admissions for the period 2016/2017 only seven patients have been transferred out with no adverse outcomes.

Good relationships are established with the Royal Adelaide Hospital and the Ambulance Service if needed.

Communicating with patients and carers

Information is provided at all levels by the staff and the treating clinician. Bedside handover, purposeful hourly rounding, care plans and whiteboards have enhanced the timeliness of identification and escalation of deterioration and has allowed patients and carers to be involved in the management of their care.

Information for patients on how to escalate their care is included in PPH's DVD patient information presentation and on the re-designed whiteboards.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

BLS and PLS education has been conducted for all clinical staff resulting in 100% compliance hospital wide.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Policies, procedures and protocols are well established and in accordance with best practice guidelines.

Clinical indicators include; number of falls and total patient falls resulting in injury. PPH's results are well below the target of 0.03% and 0.05% respectively.

As part of a quality improvement initiative, the hospital dedicated the month of April to focus on falls prevention with "April Falls Day" providing a forum for staff and patient education.

Falls prevention equipment such as red socks and falls alarm mats are readily available.

Screening and assessing risks of falls and harm from falling

The Falls Risk Assessment Tool (FRAT) is the validated tool used on admission for both inpatients and day patients. High risk patients if identified are assessed more thoroughly and falls risk mitigation strategies are put in place. Physiotherapists are actively involved if a patient is deemed high risk.

Preventing falls and harm from falling

There have been a number of quality initiatives to assist in the reduction of falls and falls prevention including; purposeful patient rounding across all clinical units, education and training for both the staff and patient, patient information leaflets, equipment and aids, new beds with low lighting and new hand rails.

The clinical handover process also includes discussion of those patients identified as high falls risk. Discharge planning includes information regarding falls risk and associated management strategies as evidenced in discharge summary letters to GPs and referral groups.

Communicating with patients and carers

The hospital provided evidence of their proactive approaches to engage with and support patient's involvement in planning their care and falls interventions.

Existing and newly developed patient information brochures have consumer input in relation to content and visual representation.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM

4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure,	SM	SM

	treatment or investigation is regularly monitored		
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are	SM	SM

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

Documenting patient information

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

Managing blood and blood product safety

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

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Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are	SM	SM

	periodically audited to identify at-risk patients with documented skin assessments		
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system	SM	SM

	• communication about clinical deterioration		
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Recommendations from Current Survey

Not applicable.

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Recommendations from Previous Survey

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation

Recommendation: NSQHSS Survey 0215.2.2.1

Recommendation:

Identify and implement a mechanism for involving consumers and/or carers in strategic and operational planning.

Action:

Parkwynd's previous Consumer Consultant resigned from the role in June 2015.

Appointment of new Consumer Consultant September 2015.

Action:

Consumer Consultant to be present at meeting for annual revision of strategic and operational planning with Hospital management, which is inclusive of further consultation and approval of final outcomes.

Management committee terms of reference updated to include identification of mechanism for involving CC in Parkwynd's strategic and operational planning activities, which ensures 'The development, monitoring, completion and evaluation of strategic and operational planning in consultation with hospital Consumer Consultant'. This will also reflect the Quality/Risk committee terms of reference which includes the development, monitoring, completion and evaluation of strategic and operational planning in consultation with hospital Consumer Consultant'.

Parkwynd's GM/DON instigated Hospital Strategic Planning group meetings in 2015 with the Consumer Consultant attendance. Parkwynd's Consumer Consultant participated in discussions and consultation with hospital management forwarding suggestions regarding strategic planning. Consumer Consultant was present for finalised updated information presented by GM/DON. Meetings documented and minuted.

Completion Due By: January 2016

Responsibility: GM/DON/QM

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Evidence provided clearly identified the Consumer Consultant (CC) is now very much involved as an active member of the Quality/Risk Committee (QRC) and present at senior management meetings in relation to strategic and operational planning activities. This insures the CC is able to provide input into the development, monitoring of service delivery, completion and evaluation of strategic planning through discussion with the management team and is able to put suggestions forward for consideration as the consumer representative. This process also applies to the QRC where the CC is able to discuss consumer issues and provide suggestions for improvement in supporting consumer input into service delivery within the hospital.

This recommendation is met and now closed.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Survey 0215.2.6.2

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Action:

Parkwynd's previous Consumer Consultant resigned from the role in June 2015.

Appointment of new Consumer Consultant September 2015.

Parkwynd's Consumer Consultant conducted education with clinical staff at the hospital's annual education day November 25, 2016. This has now been added to the itinerary for all future education days.

2017/18 plan - education from Consumer Consultant is to also include the hospital's administration staff, hotel services staff and maintenance staff.

Completion Due By: November 2016

Responsibility: QM/CC/Educators

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The CC has been actively involved in discussions with clinical staff and has also been part of the annual mandatory education training day for clinical staff, providing face-to-face education as the consumer advocate and making suggestions / improvements in meeting consumer needs. This will become part of all future mandatory education days. In 2016, a quality activity was undertaken whereby a mystery patient wrote an evaluation and suggestions for staff relating to her episode of care as an inpatient. The letter was published in Parkwynd's staff Newsletter, discussed at both QRC and Medical Advisory Committee (MAC) and posted on noticeboards throughout the hospital.

This recommendation has been met and is closed.

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Combined

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

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

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Surveyor - NSQHSS V01

Core

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

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	8	1	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**208**	**1**	**209**

Developmental

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

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

NSQHSS Survey

Organisation : Parkwynd Private Hospital
Orgcode : 320172

Combined

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

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	10	1	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**255**	**1**	**256**	**Met**