NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Pine Rivers Private Hospital

Strathpine, QLD

Organisation Code: 72 11 61
Health Service Organisation ID: Z1010011
Assessment Date: 02/04/2019 to 03/04/2019

Accreditation Cycle: 1

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

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Introduction

Pine Rivers Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 02/04/2019 to 03/04/2019. The NS2 OWA required 3 assessors for a period of 2 day(s). Pine Rivers Private Hospital is a Private organisation. Pine Rivers Private Hospital was last assessed at EQuIPNational Periodic Review on 29-30/03/2017.

Below is the Health Service Facility (HSF) reviewed in this assessment:

Health Service Facility Name	HSF Identifier
Pine Rivers Private Hospital	101174

General Discussion

Assessors noted strong executive leadership encouraging recovery oriented and informed care processes which were consistent with the requirements of version two of the National Standards. Evidence was sighted of commitment to improve training and skillmix to ensure the provision of mental health care, consistent with contemporary and evidence based best practice. Staff have easy access to policies.

Assessors were impressed with the quality of risk assessments and care plans sighted during the survey.

There was evidence of patient involvement in care planning and the discharge planning process. Active patient participation in the clinical handover process was evident. The impressive “care boards” in each patient bedroom with their distinction white marker pens facilitate a two-way flow of information, providing an ideal space for goal reminders, daily tasks and communication. It was obvious these boards are well used.

Multiple evidence of opportunities for patients to provide feedback and follow up actions being taken was noted.

Assertive action is under way to address the new standards' actions associated with Aboriginality. Staff training in cultural competency is occurring and this will hopefully assist in reducing the numbers of patients (25%) not currently answering the admission question about aboriginality.

The physical environment of Pine Rivers demonstrates organisational commitment to the provision of facilities which are immaculately clean and pleasant - a valuable contribution to the creation of a therapeutic environment. A comprehensive therapeutic program for both inpatients and day patients is offered. Assessors were also impressed with the engagement of consumer consultants and the contribution they are making to patient recovery.

This survey was conducted in April 2019 over two days with three assessors. The licence to operate the hospital was sighted and is dated 25th January 2019.

Summary of Results

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

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

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

Pine Rivers Private Hospital

Sites for Assessment

Sites for Assessment - Pine Rivers Private Hospital

Pine Rivers Private Hospital HSF ID:101174	
Address: Dixon Street STRATHPINE QLD 4500	Visited: Yes

Pine Rivers Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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

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

Not Applicable	

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

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

Assessment Team Summary:

The assessment team was impressed by the strong culture of safety and quality at Pine Rivers Private Hospital (PRPH). PRPH is one of the many health facilities in the Healthscope group. The Healthscope Board receives monthly reports on safety, quality, financial and other performance KPIs from all of the hospitals and where a hospital is falling below a KPI benchmark, that hospital is promptly asked to respond with an action plan. PRPH is performing well against all reporting measures. The Healthscope Shared Learning report enables the staff at PRPH to share and learn from other Healthscope hospitals improvement initiatives.

Healthscope has developed the Healthscope Aboriginal and Torres Strait Islander (ATSI) reconciliation action plan which is now with the Commonwealth Reconciliation committee for final approval. There are numerous and visible patient notices and art works located around the hospital which recognise the land owners and provides patient information relevant to ATSI. PRPH has analysed their admissions and found that 2.41% admission in 2018 identified as ATSI. Seventy-five percent (75%) of patients admitted to PRPH answered the admission question on whether they identified as ATSI. The hospital has commenced further training for intake staff and nursing, in order to improve the rate of answering of the intake question. A training video on the importance of culture identification and how to ask the question on cultural identification is being rolled out.

Patient safety and quality systems

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

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

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

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

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

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

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

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

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

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

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

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

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Policies are reviewed and updated by the relevant Healthscope committee and this process also occurs at the PRPH level. Local policies are reviewed every three years but if the policy risk rating requires annual review this occurs. Policies are located on the intranet site for all staff to access.

Healthscope has a Safety and Quality Plan and a Clinical Governance Framework. The PRPH Quality and Safety Plan is developed in accordance with the Healthscope plan. The local plan is reviewed at the Quality and Risk committee. Reports are made available to Healthscope corporate office, to PRPH staff and to consumer consultants, who are members of the Quality and Risk committee. Selected key quality and safety KPIs are graphed and posted on the staff notice board.

A risk register is maintained by Healthscope and the PRPH risk register reflects the corporate wide risks as well as local risks. The RiskMan platform holds the risk register. Risks are reviewed by senior management and detailed risk mitigation actions are reviewed and updated where necessary. The number of risks on the register is fairly large and risks are not archived very often.

Incidents and complaints are managed well and the service meets the timeframes for responding to and completing actions on incidents and or complaints. 100% of staff have completed the Open Disclosure training.

Medical records, paper based, are held at the point of care. Audits are conducted, as per PRPH audit schedule, to ensure the records meet standards. Audit results are very favourable. Day patient notes from group work are entered into the medical record under a separate tab within the file.

PRPH is conducting a gap analysis as per ACSQHC Advisory AS 18/11. An action plan has been developed which is monitored and updated by the relevant committee. PRPH will include an action which to address the management of those patients who wish to opt out of My Health Record.

Clinical performance and effectiveness

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

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

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

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

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

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

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

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

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

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

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

Assessment Team Summary:

There are effective Healthscope policies covering orientation, mandatory training and education and training. The Mandatory training table outlines which training course is mandated for which category of staff, the frequency of training/refresher, how long the course takes and the mode of training. This is a very good example of informing staff on mandatory training requirements. In 2018 Healthscope launched a “Back to the Bedside” initiative to get staff out on the wards and at the bedside more often. A strategy to achieve the initiative has been to reduce the 15 hours of mandatory training down to five hours of mandatory training. Another strategy has been to commence an Employee Engagement committee, which the Consumer Consultant attends. The staff provide feedback on work practices such as the amount of paperwork, how to reduce double handling of papers, etc, as ways to gain more time on the wards and at the bedsides. The strategies are reviewed to ensure the safety and quality of clinical service delivery is not jeopardised.

The Employee Engagement committee is an enabler to the cultural transformation journey which PRPH is on. A PRPH culture is one that embraces ATSI cultural awareness and competency as well as consumer centred care and trauma informed care. PRPH has reached out to connect with the local ATSI community and the hospital has also connected with the Prince Charles Hospital’s ATSI Reconciliation group to share strategies.

Performance review is well managed with a current compliance rate at 88%. Actions are implemented to improve the compliance rate. Credentialing of nurses, allied health staff and VMOs is thorough and effective. The system called Cgov is used to input credentials for medical and allied health professionals to track and monitor credentialing requirements. VMOs have scope of practice requirements to meet regarding ECT and TMS in order to practice these interventions.

Best practice guidelines are available to staff from the Healthscope Intranet (HINT). The assessment team was impressed that averaged HONOS and MQH14 measures on discharge for each patient are presented and discussed at relevant committees, and any outliers are discussed at the Medical Advisory Committee and or Psychiatrists committee. The average scores are also shared with other Healthscope mental health facilities as part of the Shared Learning report. An outlier in clinical outcome measures might form a risk for which management would then implement appropriate processes and systems to eliminate the risk.

Safe environment for the delivery of care

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

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

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

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

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

PRPH has a designated position of maintenance officer and a Facility Services Manager position who are responsible for preventative maintenance and general maintenance of the facility. There is good evidence that management and staff place a high priority on ensuring the safety of the facility. Each morning there are patient and staff meetings where patients can raise maintenance or other safety concerns. The meeting is minuted and actions are taken to address any issue raised by the patients. This was confirmed by talks the assessment team had with patients.

PRPH has developed a very good Disaster and Business Continuity Plan. It is reviewed and updated and tabled at the WHS committee. All maintenance issues are also tabled at the WHS committee. A very thorough and detailed ligature audit template is completed bi-annually. Resulting from safety audits six patients' rooms have been improved to eliminate potential ligature points. Actions from the ligature audit are tracked by the Quality and Risk committee.

Throughout PRPH there are Aboriginal paintings depicting the welcoming and joining of the two cultures and there are posters and pamphlets in the foyer acknowledging the traditional owners of the land which the hospital sits upon.

Signage for the hospital, external and internal, is clear and well presented.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

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

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

Assessment Team Summary:

Healthscope has numerous policies to guide the organisation in partnering with consumers. The PRPH consumer partnership strategy was developed by a PRPH consumer and endorsed at the Consumer and Carer Committee. There is very good evidence, supported by conversations with consumers, that the executive team and staff value and respect the voice of the consumer and carers in the planning of services, the design of the facility and in the analysis of quality and safety performance.

Extensive consultations with consumers was held when the bedrooms were being redesigned and further consultations will be held when the internal courtyard is redesigned due to safety concerns.

PRPH use an online consumer experience survey after each discharge. Response rate for the Qualtrics electronic survey is very high and the general satisfaction of consumers for the treatment and care received is in the 80th percentile. The assessment team noted that the consumer rating for the quality of treatment and care received has been declining since September 2018. This fact has been discussed at Quality and Risk committee and the service believes the decline is due to the change in (patient) leave policy and a stricter enforcement of the no smoking policy. A communication strategy with inpatients, which actively includes the consumer consultant, about policy changes is being implemented.

PRPH reports to Healthscope on various improvement processes in partnering with consumers, e.g., satisfaction survey results, quality activities which consumers have initiated and all reports on partnering with consumers becomes a part of the Healthscope Shared Learning report.

Partnering with patients in their own care

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

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

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

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

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Healthcare rights are provided to consumers and carers on admission. Healthcare rights are also included in the patients' welcome pack at the bedside and posters on patient rights and responsibilities are posted throughout the hospital. All information on rights is consistent with the Australian Charter of Healthcare Rights.

Healthscope has clear policies on obtaining consent to treatment, as well as financial consent. Audits are conducted on consent compliance at admission, financial arrangements, ECT and TMS. Audit results are very good, being at 100% or close to 100% compliance. The financial consent form meets the requirements of Advisory AS18/10.

The assessment team did note, however, that the rTMS consent form was not sufficiently detailed in regards to the treatment. The standardised ECT consent form is very detailed regarding the frequency of treatment, location of instrument placement (bilateral or unilateral), etc. The assessment team's view is that for best practice the rTMS consent for needs to be redesigned to provide more detailed information about the planned rTMS treatment in order that the consumer is giving informed consent. A recommendation has been made at Action 2.4.

PRPH has implemented patient care black boards in each bedroom. The assessment team was impressed by the information it contains and that the consumer and staff at the bedside handover update the care board information daily. This is a very good initiative. The patients the assessors spoke with agreed that the care boards are very useful.

Care plans are signed by the patient and audits demonstrate 100% compliance. There is a policy on Advance Care Directives. All patients are asked at admission if they have an advance care directive and if they do have one it is placed at the front of the medical record. Information is also obtained at admission if the person has a power of attorney or Guardianship order.

Action 2.4
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Pine Rivers Private Hospital
Assessor Rating: Met with Recommendation
Assessor Comment: Healthscope has a policy on consent to medical/surgical treatment. Audits conducted by PRPH in August 2018 on completion of ECT and TMS consent forms were 100% compliant. However, the assessment team noticed that the content of the Transcranial Magnetic Stimulation consent form was not best practice, not as detailed as that provided in the Electro Convulsive Therapy consent form. The form did not indicate the number of rTMS treatments, and it did not indicate the frequency of the treatments. Other information from the Psychiatrist's rTMS prescribing form could be included on the patient's consent form. It is essential for a patient to be able to give informed consent the details of the treatment to be performed is clearly stated on the consent form. The patient also needs to be informed that a new consent form will need to be signed if treatment is to continue after the designated number of rTMS treatment has been completed.
Recommendation:
Following consultation with staff and consumers, alter the content of the rTMS Informed Consent Form to include more detailed information on the treatment proposed.
Risk Rating:
Low
Risk Comment:
This is a low risk to the organisation based on evidence that the safety and quality of rTMS procedures at PRPH are managed well.

Health literacy

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

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

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

Assessment Team Summary:

All patient related information pamphlets produced by PRPH have input from the Lived Experience Advisory Group (LEAG) and the final product is endorsed by the LEAG with a mark of approval on the pamphlet.

Each inpatient ward has a morning meeting with patient and staff to communicate the day's activities, groups and any housekeeping issues. The staff tell the joke of the day or sing a song which is a very good ice breaker and consumer engagement.

Extensive and appropriate information is provided to patients on discharge regarding community support services and of course, the excellent day programs offered by PRPH. Discharge summaries by the VMO and nursing staff are completed within prescribed timeframes.

About 4% of the admitted patients are veterans. PRPH are very conscious about how veterans from different arms of the defence force may interact with one another. PRPH has also made linkages with the local defence force and its support services to ensure PRPH veteran patients receive the appropriate care and referral upon discharge from PRPH.

Partnering with consumers in organisational design and governance

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

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

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

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

Assessment Team Summary:

PRPH clearly demonstrated that consumers, carers and consumer consultants are involved in the governance, design and evaluation of the hospital's healthcare. The part time Consumer Consultant attends the Quality and Risk Committee and the Employee Engagement committee. The Lived Experience Advisory Group is documented on the PRPH committee organisation chart.

The LEAG will be advertising for new members soon and the group aims to have membership that reflects the diversity of the community and the inpatient population.

The Consumer Consultant along with the two volunteer consumer consultants and others have developed a very good Consumer Consultant Resources Manual. It contains a schedule of audits that the consultant will be involved in, the mandatory training required to complete, PRPH consumer engagement strategy, quality activities planned and other very useful information. This is one of the best consumer consultant resource manual the assessment team has ever seen. Well done. It was evident from talking with the consumer consultants that they have very many good ideas that they would like to commence. It will be suggested that the LEAG develop a prioritised strategic and action plan for the financial year as their guiding business plan.

PRPH has been very supportive to consumers by providing education and ongoing support to assist the consumers in understanding performance measures and evaluation of health outcomes. PRPH consumer consultants were actively involved in the development of the Healthscope's Foundations training program for consumer consultants across Healthscope facilities.

PRPH has connected with the local ATSI community health centre to better understand and respond to cultural differences when making referrals or other changes to the hospital services. ATSI brochures are available for staff to get from the Healthscope intranet. The Consumer Partnership Strategy 2019/2020 has a strategy and actions to address Closing the Gap. All committee meetings commence with an acknowledgment of country.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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

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

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

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

Assessment Team Summary:

Infection control matters are discussed at the Quality and Risk Committee - an appropriate arrangement for a small hospital. There is a consumer representative on this committee. Since July 2018, an infection control nurse resource is available one day a fortnight. She is a gold standard hand hygiene auditor. The organisation uses the contracted services of HICMR which provides expertise, advice, contemporaneous infection control policy and a range of auditing tools. Policy documents are available to staff online with a hard copy available within the facility. There is a search function to enable easy retrieval of policy.

Pine Rivers has a representative who attends the Healthscope infection "cluster" Webex meetings. This provides an opportunity for networking with other Healthscope organisations and for "shared learnings" related to infection control matters.

Records of completion of infection control principles training showed compliance rates for clinical and non-clinical staff at 95% and 94% respectively.

Annual audits are conducted on policy compliance, aseptic non-touch technique, invasive devices and antimicrobial stewardship. Audits are also conducted on the contents of clinical waste bins, and thermostatic mixing valves. Whilst there is a KPI for bacteraemia infections, there have been none reported in the last four years.

Outcomes of surveillance and auditing activity are reported to the Quality and Risk Committee. The infection control nurse shares an office with the Quality Manager. Improvements have been made to the management of sterile stock. Action plans are developed after the scheduled HICMR audits. It was reported however that following the last audit, the only recommendation was one to ensure that Personal Protective Equipment for staff was more visibly stored. This has been actioned.

Assessors noted that the My Healthscope website for Pine Rivers provided Hand Hygiene compliance data for 2016 and 2017 (88 and 90 % respectively – above the Healthscope target of 80%) but that there was no data displayed for 2018.

Infection prevention and control systems

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

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

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

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

Not Applicable	

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

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

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

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

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

Assessment Team Summary:

Pre-admission screening includes questions focused on fever and respiratory symptoms. There are Healthscope policies and Key Performance indicators to monitor Hospital acquired infections. In the event of a significant infection issue being identified or emerging during a patient's admission, transfer to a more appropriate health facility would occur. This would be most likely to be to the closest Healthscope Private Peninsula Hospital or the public Prince Charles Hospital.

Pine Rivers contributes data to the My Healthscope website. This site also contains infection control specific information for patients on the following themes: handwashing, covering mouth when sneezing, reporting infections, completing full courses of antibiotics, reporting if room or equipment has not been sufficiently cleaned and reporting and redness or swelling.

All patients are required to have a medical review within 24 hours of admission. There is also access to a nearby general practitioner.

Infection control information is available in every patient bedroom. Instructions on the five moments of hand technique are posted above most wash basins in public areas. Hand wash gel is available in the patient dining room.

Patients receiving maintenance ECT are phoned two days before the scheduled treatment to confirm their (non) infection status.

Whilst the RiskMan system would be used for reporting of infection issues, it was stated there have been no such reports. Over the past five years, there have been no reported instances of staphylococcus Aureus or Clostridium Difficile.

Any infection issue identified through pathology results would be picked up through monitoring of the pathology results. HICMR policies focused on standard and transmission-based precautions are available to all staff online. There is an "outbreak" checklist.

The recently appointed infection control nurse is a hand hygiene auditor. The organisation is reporting 100% compliance with hand hygiene training and an improvement from 80–90% in observed compliance. Results are benchmarked against seven peer hospitals within the Healthscope Group.

Practice of aseptic technique is largely confined to cannula insertions in the ECT suite and the administration of Intramuscular injections. Training in Aseptic technique is reported to show 95.9% compliance. Posters with photograph displays of appropriate aseptic technique are on display in the ECT procedure room

Monthly room clean 15 item audits are conducted with results reported quarterly. For shared room accommodation the privacy screens are changed after a patient is discharged. There is a schedule for the dry cleaning of window curtains. All areas of the hospital showed signs of effective and conscientious cleaning.

To assist in improving workforce immunisation, an immuniser is now running clinics. New staff are required to be fully immunised before commencing work.

Reprocessing of reusable medical devices

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

Assessment Team Summary:

All ECT equipment is disposable. There are policies for the cleaning of tympanic thermometers and blood pressure cuffs.

Whilst there is no sterilising facility, the organisation completed a HICMR gap analysis against AS/NZS 4187:14 in 2017. An action plan has been developed. Improvements have been made to sterile stock storage arrangements. The organisation reports 100 % compliance.

Antimicrobial stewardship

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

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

Assessment Team Summary:

Antibiotic usage in this hospital is small. The AMS program is based on a “traffic light” system. Only “green” antibiotics are kept in stock. Monitoring of antibiotic usage is provided by the HPS pharmacy which provides on-site pharmacy services and representation on the Medication Safety Committee. AMS is an agenda item on the Quality and Risk Committee. Data is submitted to the National Antimicrobial Prescribing Survey annually. Processes were reviewed and enhanced a year ago to improve data quality.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

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

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

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

Assessment Team Summary:

Pine Rivers has a Medication Safety committee with membership including Executive, pharmacist, General Practitioner and nursing staff. Since last survey, there has been an increase in pharmacist hours, achieved by moving to a contacted service with HPS. There is now five hours of on-site pharmacist service three times a week. Improvements associated with this contracted arrangement include increased clinical hours, access to the HPS safety systems, improved medication education for staff and backup pharmacy service in the event of sickness. There is access to an on-call pharmacist during the weekend.

A variety of Healthscope policies and procedures, consistent with relevant legislation provide guidance to staff on medication management issues.

A member of staff participates on the Healthscope National Medication Safety Team – an online forum which enables shared learnings across the different Healthscope facilities.

Graphs of medication incidents logged during 2018 were sighted. There were never more than four per month. Pine Rivers KPI indices fall below the expected figures for total medication events There have been no adverse medication error events requiring intervention. Audit data is reported to the Quality and Risk Committee. A consumer sits on this committee.

Improvements to medication management have included the provision of signage in medication administration areas to reduce noise and so minimise risks of distraction which may result in medication administration errors. The organisation contributes data to the National Medication Chart Audit on an annual basis. One identified opportunity for improvement is the completed signing of telephone orders within the required timeframe. This is the subject of a recommendation.

Job descriptions outline the scope of practice for registered nurses and enrolled nurses in relation to medication. Annual audits of prescribers' signatures are undertaken. Audits of individual personnel files have shown that 100% of medical and nursing staff have the appropriate registration authorisations.

Action 4.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Pine Rivers Private Hospital
Assessor Rating: Met with Recommendation
Assessor Comment: The organisation has identified a recurring difficulty with getting telephone medication orders signed by the prescribing physician within 24hr timeframe required by Healthscope policy. VMOs on call may not have a scheduled visit to the hospital planned within this time period. The organisation has attempted to resolve this issue by suggesting faxed signatures. Approval from the relevant regulatory body has not been forthcoming. There have been no significant reported incidents associated with delays in obtaining signatures, however it is not appropriate to have an unsustainable policy and work practice.
Recommendation:
The organisation review its existing policy related to telephone orders, clarify clinician expectations and ensure they reflect Queensland legislation and reasoned clinical practice.
Risk Rating:
Low
Risk Comment:
A failure to have appropriately signed medication charts may increase the risk of subsequent confusion about what medication has actually been administered resulting in inappropriate clinical decision making.

Documentation of patient information

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

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

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

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

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The nurse and psychologist intake team complete a thorough clinical assessment. This enables capture of information about previous and current drug management. This information is compared with previous information obtained at the time of the pre-admission assessment and any information obtained from carers or other clinicians such as general practitioners. Review by the pharmacist then ensures completion of Best Possible Medication History.

The Medication Management plan is a four-sided document containing discrete sections for:

a) Medication Management plan
b) A list of recent changes to medicine
c) Sources of medication list
d) Medication risk identification
e) Medication history checklist
f) Medications taken prior to presentation to hospital
g) Medication changes during admission
h) Comments
i) Medication discharge checklist
j) A referral for recommending a Home medicines review

Audits of the Medication Management Plan in September 2018 showed a 90% compliance rate. The plan also contains a section for identifying allergies and adverse drug reactions.

The RiskMan reporting system would be used in the event of an adverse drug reaction. There are relevant policies related to reporting but it was noted that in the past two years there has been no issue requiring notification to the Therapeutic Goods Administration. The Director of Nursing is responsible for ensuring all clinical staff are made aware of any TGA issued alerts.

Continuity of medication management

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

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

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

Assessment Team Summary:

The pharmacist is responsible for reviewing medication charts whilst patients are in hospital. There is a "ticking" system by which a doctor indicates notice has been taken of any pharmacist intervention or suggestion related to medication. Pharmacists use the Clinpod incident reporting system.

Within its peer group (other Healthscope facilities), Pine Rivers is one of the better performers in terms of medication incidents.

The different sections of the Medication Management Plan provide clinicians with appropriate information to ensure sound clinical decision making.

Bedside clinical handover provides an opportunity for patients to be provided with additional information about medications. The information board in each patient bedroom provides patients with an opportunity to flag any questions they may have.

The pharmacist provides each patient with a medication profile at the time of discharge.

Medication management processes

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

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

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

Assessment Team Summary:

Decision support tools available for staff include: MIMS online, Therapeutics Guideline – online and the Australian Injectable Drugs Handbook.

Appropriate storage arrangements for drugs were confirmed during this survey. Daily checks are made and cold chain processes were in place. Policies supporting drug storage and disposal are consistent with legislative requirements.

High risk drugs have been identified as warfarin, opioids, insulin and clozapine. TallMan lettering and use of individual patient trays contribute to safe storage systems.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

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

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

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

Not Applicable	

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

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

Assessment Team Summary:

Overall the assessors felt the intake, assessment, care planning and discharge process to be of a very high standard underpinned by appropriate policies and guidelines. There was a clearly demonstrated commitment by all staff to provide a patient centred therapeutic journey for each patient that included family and carers.

Assessors were impressed with the presentation, relevance and availability of all evidence provided in support of the criteria and actions.

The clinical governance system is inclusive of a risk register, which is monitored on a monthly basis; and a Quality Management Plan that outlines priorities and actions identified through peak committees. Terms of Reference, attendance, minutes and actions arising demonstrated that the governance structures within PRPH are sound.

An exhaustive audit schedule is in use; it schedules the frequency of each audit according to risk level, past results, spread of workload and any relevant issues which may have arisen.

Initial intake and assessment procedures are clear and used to identify suitability of patients for admission including their general physical and mental health. Measures to ensure the safety of patients and staff following referral and admission include, a comprehensive care plan, use of the recovery and relapse prevention plan booklet and a daily assessment of risk and mental state assessment.

Position descriptions include a description of quality and safety responsibilities with annual staff review linked to these responsibilities with the objective to ensure that all clinicians are appropriately credentialled and working within their scope of practice.

If the patient becomes unwell based on a physical or mental health assessment, the escalation of care and patient transfer procedures are utilised to ensure safe transfer of the patient to a more suitable health facility, using ambulance and police if required.

The principles of recovery oriented mental health practice are embedded within group activities and day programs. The diverse programs offered are displayed in the units and discussed in the morning patient meeting. Mental health wellbeing is promoted to ensure all patients develop strategies with support to maintain their own mental health.

Assessors reviewed a number of medical records, all available at point of care, and found them to be well structured and integrated, and suitably organised to facilitate various regular audits of documentation, patient pathways, care plans, alert sheets, and medication regime.

Developing the comprehensive care plan

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

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

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

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

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

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

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

Assessment Team Summary:

There is a comprehensive assessment completed on all patients referred to PRPH. The initial triage and assessment completed at admission, forms the basis for admission criteria and care options ensuring patient needs are understood and considered in the planning and delivery of care. Assessments are completed with the patient and when relevant their carer.

Risk assessments that include malnutrition screening, pressure area, risk of falls and risk of harm to self or others are incorporated within the admission and updated as required. Monitoring of risks helps to ensure that appropriate plans are in place to mitigate potential escalation of behaviours. Screening for infection status and nutrition formed part of the admission documentation and was evident in the medical records viewed by the assessors. Care plans were signed by the patient demonstrating involvement and collaboration with ongoing care planning and treatment options. However, signatures of family/carers were not always evident, so it was difficult to determine if they had been involved in the process. Few care plans viewed by the assessors had outcomes and dates recorded and it is suggested a more robust system be implemented to ensure care plans are regularly reviewed and updated.

It was pleasing that clinician and patient outcome measures were collected as per service protocols and informed clinical care at the multidisciplinary team case reviews.

The admission pack given to patients on admission contained a recovery and relapse and prevention plan booklet, designed with consumer input, that followed the patients journey. Patients are encouraged to identify support people in the development of recovery and relapse prevention plans. PRPH has a broad view on carer selection with nominated friends and neighbours considered valued carers.

Consumers with a lived experience of mental illness are included in staff training activities with a particular focus on recovery orientated practice.

The social worker and discharge coordinator have established links with external providers to assist when necessary with patient needs on discharge. On discharge patients are provided with a range of community information and resources that support community integration and social inclusion.

PRPH has conducted a gap analysis as per ACSQHC Advisories AS 18/14 and AS18/15. A draft comprehensive care plan including screening and assessment for risk of harm has been developed which is being monitored and updated by the relevant committees.

Delivering comprehensive care

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

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

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

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

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

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

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

Assessment Team Summary:

PRPH does not admit patients who are at end of life with conditions that require end-of-life care. On admission, if patients have an Advance Care Directive this is placed on their clinical record and a note made on their alert sheet.

Daily mental state examinations and risk assessments support the identification of any change in a patient's status and guide ongoing management plans. The risk assessment processes in place ensures that clinical deterioration is identified as early as possible and escalated. Any incidents are evaluated for compliance through audit and incident review.

The frequency of observations varies if clinically appropriate and determine when a patient's condition has deteriorated and trigger an escalation of care.

Assessors were able to observe routine shift-to-shift ISOBAR handover and were impressed with the completeness of information provided on each patient in the unit.

Duress response is worn by all clinical staff to respond to emergencies and there are call buttons identified in each patient bed room if assistance is needed.

Patients and carers are encouraged to speak with staff at any time if they feel there is any deterioration in a patients physical or mental state.

There are instructions on how to call for assistance in an emergency in each patient's bedroom and an' Escalation of Care' information brochure has been developed with input from consumers and is included in the admission pack.

Activation of Rapid Response was seen to be part of the in-service education provided. Clinical Staff are trained in basic life support and annual refresher training and competency evaluation is mandatory. Emergency equipment was seen to be available and routinely checked.

The ambulance service is called immediately if any patient's general physical condition deteriorates so advanced life support can be provided as well as transport to an acute care facility.

Minimising patient harm

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

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

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

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

Action 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls

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

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

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

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

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

Not Met	
Not Applicable	

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

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

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

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

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

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

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

Assessment Team Summary:

There is a system wide process (RiskMan) for reporting and managing risk and a raft of risk assessments that are conducted at intake, admission and during the patients journey through PRPH.

Daily mental state examinations and daily risk assessments were evident in patients' medical records to assist with identification of any change in a patient's status and guide ongoing management plans.

The Hospital Educator provides in-service training in care planning and clinical handover for all clinical staff. Education in MMSE enables staff to identify early signs of cognitive decline in patients and to implement appropriate observations and management options.

On discharge patients who are deemed at risk are followed up and supported by the discharge coordinator to provide any additional support that may be needed. Day patients receiving ECT receive a telephone call to monitor their progress post discharge.

There is good documentation of policies and guidelines which guide a structured process for the assessment, prevention and management of pressure areas as well as falls and harm from falls.

Screening and assessing risks of falls commences during the intake process and is documented in the clinical record using a falls risk assessment tool.

Mobility aids can be used by patients during admission following a risk assessment and also noted on the front of each patient's medical record was an alert page which highlighted any potential falls risk. Patient falls information has been developed in conjunction with consumers is made available with several examples provided at the time of survey in the form of patient Information brochures.

It was pleasing to see April Falls Month promoted with displays and information on strategies to prevent falls.

Prior to admission patient mobility is discussed during the initial intake assessment as the daily programs require a level of mobility and activity.

The assessment contains information pertaining to any current pressure injuries or wounds and includes any history of recent infections.

There have been no instances of pressure injury at PRPH in past years, but it is evident that there is vigilance in the assessment and maintenance of the prevention of pressure injuries.

Only voluntary patients are admitted to the hospital. Seclusion is not practised. Screening processes pre-admission or at the time of proposed admission would identify any issues of cognitive impairment and delirium. In such cases alternative care would be arranged.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

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

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

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

There is a robust intake/assessment process where patients are informed of their rights and responsibilities and although only a small percentage of clients are from a CALD background, the PRPH is able to provide interpreter services and culturally appropriate meals if required. Consent forms were evident in the medical records reviewed by the assessors and informed by the Consent Policy.

Communication was seen to embrace all aspects of PRPH and across all domains verbal and written. From a governance perspective, there are a range of policies, guidelines and procedures to support the clinical handover process.

Clinical staff use a structured framework, ISOBAR and there is evidence of actions to increase the effectiveness of clinical handover using contemporary practice.

Any incidents involving clinical handover are registered on RiskMan.

The bedside handover observed by the assessors had a systematic approach to the handing over of information covering ongoing care, medications and discharge plans (if appropriate) and feedback from the patient and family and carer if they were present. Patients were able to have their immediate needs and concerns identified and they described to the assessors a high level of satisfaction with being included in the handover process. The care boards in each patient's bedroom are updated and referred to during the bedside handover.

The communication board in each unit contained information on each patient including leave, diet, risk and possible discharge dates and was updated as necessary and complimented the shift to shift handover process.

Discharge planning commences on admission and is coordinated extremely well with both family/carers included in ongoing discharge plans. It is acknowledged that timely, accurate patient discharge summaries are a key critical component of the handover of patients.

Daily morning unit meetings of patient and staff provide another source for engagement and communication. Meetings have rotating agenda items but unfortunately little was recorded in the minutes viewed by the assessors to reflect discussions and patient issues that were raised.

Photos of staff displayed each shift was an excellent way to communicate to patients and visitors who was on duty in each unit.

There is a raft of measures in place at PRPH to obtain and collect feedback information from clients about services and care provision. Complaints and compliments are handled in a timely fashion and reported to the executive. Arrays of "Thank you for all you have done" cards completed by patients were evident in both units.

Orientation for new staff includes input from consumers which provides a valuable insight into the lived experience of care and recovery. It was noted consumers were not currently involved in the staff recruitment process although they had input into the questions to be asked at interview.

The impressive range of programs and activities available to both inpatients and outpatients is evaluated routinely. They are designed to meet the needs of the patient population with evidence of suggestions being implemented and under consideration such as the addition of a gym for patient use.

Correct identification and procedure matching

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

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

Assessment Team Summary:

There is a range of policies to govern the patient identification process with a defined identification system required for use throughout the hospital.

Each patient is allocated a unique Unit Medical Record Number, which is provided at the initial point of contact. Identification labels are printed with 4 patient identifiers from the Webpas information system. A white wrist band listing the patient identifiers is required to be worn by each patient and this checked before medication is administered, prior to going on leave and when attending any treatment or program.

It was observed by the assessors that clinical and bedside handover began with the ID band check. The ID check included patients attending the day program and a recent annual audit demonstrated 100% compliance with this process.

Patients are made aware of the protocol that staff are required to follow to establish correct personal identification and this alerts them to the need for the identifying questions that are asked at each point of their care or treatment.

Photo identification of patients with evidence of consent is included in clinical records and medication charts.

Team Time-out (TTO) requirements are incorporated in well-designed procedure safety checklists for ECT/TMS. The assessors witnessed TTO sessions, and confirmed compliance with the policies, checklists and requirements.

Communication at clinical handover

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

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

Assessment Team Summary:

PRPH has systems in place to demonstrate appropriate clinical handover. The local audit schedule includes audits for clinical handover and any non-conformance areas are reviewed by the Quality and Risk committee and an action plan included in the Quality Activities Register.

Non-conformance areas are re audited and results are tabled for review and further action if required.

There is a patient-centred trauma informed approach to clinical handover. Staff use the ISOBAR format at the daily bedside handover and clinical handover that occurs between each shift. ISOBAR is well embedded in documentation as well as verbal handover. The three patient identifiers were used at all clinical handovers observed by the assessors.

Clinical handover sheets used at shift handover contained diagnosis, past history, risk investigation and any discharge plans. The shift to shift handovers were done in a confidential area and in a timely manner.

Patients are given the opportunity to be involved in the daily bedside handover at the change of shift from morning to afternoon. They are provided with a clinical bedside handover brochure on admission and families and carers are encouraged to be present.

Patients are reminded of the shift handover times on admission and at the daily patient morning meetings. Although patients are ambulant, having handover in their bed area helps ensure a degree of confidentiality. A recent audit of bedside handover had 100% compliance of all domains in both units. It was obvious that the bedside handover was embedded in routine clinical practice. The personal care boards in each patient bedroom were updated during bedside handover.

Discharge summaries are given to the patient and to the referring GP within 24 hours of discharge. This process is audited for compliance. Assessors witnessed the formal handover process that occurs for day patients who have received ECT. The patient is escorted to the car and there is a systematic communication of handover to the car driver (carer) to reinforce post treatment instructions.

Communication of critical information

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

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

Assessment Team Summary:

The risk management processes and framework are comprehensive and appropriate to support quality and safety. There is clear process to facilitate identification, reporting, escalating and controlling risks and staff demonstrated an understanding of their role in minimising risk and contributing to safety and quality in their delivery of health care.

At intake all patients are screened for mental health, substance use and other clinical risks to ensure PRPH is the most suitable place to meet their care requirements. Patients who are not suited to the programs available at PRPH are referred/transferred to a more appropriate setting.

'At-risk' inpatients and outpatients are reviewed daily by the multidisciplinary team. and changes to treatment or care is documented in the clinical record. Included in the review are the Risk Screening and Assessment Tools that document relevant risk area such as nutrition, falls and pressure injury risk. All medical emergencies are responded to via a code blue protocol.

RiskMan is the reporting system for clinical incidents, complaints, compliments and management of the Risk Register.

Documentation of information

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

Assessment Team Summary:

Medical record management and documentation procedures provide comprehensive and appropriately referenced guidance to clinical and administrative staff on the creation, order, use, storage and security of clinical records.

Assessors reviewed a number of clinical records that were available at point of care in both units, and found them to be well structured and integrated, and suitably organised to facilitate various regular audits of case notes, patient pathways, management plans, alert sheets, and drug therapy to cite a few.

To further assist with patient safety a large photo of the patient was in the front of their clinical record and medication chart.

Clinical records showed clear and consistent application and completion of informed treatment/care consent processes, including specific and detailed consent to ECT, and informed financial consent procedures.

Risks were updated daily and as appropriate and alerts were easily identified on the front of the patient clinical record.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

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

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

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

Assessment Team Summary:

N/A

Prescribing and clinical use of blood and blood products

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

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

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

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

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	

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

Assessment Team Summary:

N/A

Managing the availability and safety of blood and blood products

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

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

Assessment Team Summary:

N/A

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

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

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

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

Assessment Team Summary:

It was noted that there have been no adverse events in house, related to deterioration of patients. The pre-admission screening policies of the hospital ensure that patients with high risk conditions, both physical and mental, would probably not be accepted at Pine River and alternative venues of care would be encouraged. Medically compromised patients requiring ECT for example would be referred to Prince Charles Hospital.

As a result of shared learnings from other Healthscope facility reviews changes in practice to manage code blue response is to arrange for a staff member to be present at the front of the hospital to assist and guide the ambulance staff on arrival. Following consumer feedback, the red emergency call buttons in patient bedrooms have been highlighted to make them more visible.

Detecting and recognising acute deterioration, and escalating care

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

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

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

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

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

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

Assessment Team Summary:

All patients have basic observations taken at the time of admission. Assessing medical staff are responsible for indicating the frequency of any future routine observations required. This will depend upon assessed clinical need and co-morbidities. Such orders will usually be written by the General practitioner or the attending VMO in the clinical progress notes. Patients on withdrawal regimes will probably be on a strict monitoring chart, consistent with assessed need.

To better monitor patient conditions, protocols regarding leave have been reviewed, with patients required to sign in and out. In the event a patient has not returned by due time relevant clinical staff receive telephone alerts. Leave after 8 pm is no longer granted.

The bedside clinical handovers provide patients the opportunity to be actively involved in care planning and evaluation of goal progression.

An information booklet titled Escalation of Care has been prepared for patients, carers, family and support persons. The document provides advice regarding processes to escalate care from both the ward and home environment. The overhead patient information revolving message screens in some corridors refers visitors to this pamphlet. Posters on the walls in some bedrooms provide direction for initiating an emergency call.

A hierarchy of alternatives are available in the event of a patient being identified at risk of acute deterioration of mental state. These include:

1. First point of call - the patient's treating psychiatrist
2. On call psychiatrist
3. Back up psychiatrist, if on call psychiatrist does not respond

4. Referral to Medical Director who is on 24- hour call.

The RiskMan database provides a facility to monitor logged deterioration incidents. Data provided at time of survey showed all of these were staff initiated. It was not obvious that any had resulted from a patient/carer escalation of care call. Following assessor comment during survey, before the end of the survey, large A3 sized posters had been prepared for display throughout the hospital to provide further advice to family members and patients on how care concerns could be escalated.

Currently in the patient "welcome pack", and the information pack provided in each patient bedroom, there is nothing about escalation of care.

Suggestions for Improvement:

When next reviewed, the contents of the welcome pack provided to each patient include information about escalation of care options.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

All clinical staff are required to have annual Basic life Support Refreshers. In addition, two staff who work in the ECT/TCM suite have current Advanced Life Support training. Previously this was also required of after-hours nurse managers, however this policy has been removed, given the impracticality of expecting such staff to maintain frequency of practice of this skill.

In the event of a code blue call, first responders will be the NUM and two team leaders. An additional person will need to be assigned to great the ambulance.

In the event of a significant rapid deterioration in a patient's condition an ambulance would be called and the patient transferred to a more suitable location. This might be the Healthscope Peninsula Hospital or the public Prince Charles Hospital. In the event of significant deterioration of a patient's mental state referral can be made to the local public North Metro Mental Health Service.

Following assessor comment during survey, the checklist form on the cardiac arrest trolleys was amended to indicate when an identified action identified during routine checking has been completed.

Recommendation from Current Assessment

Standard 2

Organisation: Pine Rivers Private Hospital
Action 2.4: The health service organisation ensures that its informed consent processes comply with legislation and best practice

Recommendation:

Following consultation with staff and consumers, alter the content of the rTMS Informed Consent Form to include more detailed information on the treatment proposed.

Standard 4

Organisation: Pine Rivers Private Hospital
Action 4.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management

Recommendation:

The organisation review its existing policy related to telephone orders, clarify clinician expectations and ensure they reflect Queensland legislation and reasoned clinical practice.

Rating Summary

Pine Rivers Private Hospital

Health Service Facility ID: 101174

Standard 1 - Clinical Governance

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Action	Assessment Team Rating
1.27	Met
1.28	Met

Safe environment for the delivery of care

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

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

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

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

Documentation of patient information

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

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

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

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Not Applicable
5.17	Met
5.18	Not Applicable
5.19	Not Applicable
5.20	Not Applicable

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Not Applicable
7.2	Not Applicable
7.3	Not Applicable

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Not Applicable
7.5	Not Applicable
7.6	Not Applicable
7.7	Not Applicable
7.8	Not Applicable

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Not Applicable
7.10	Not Applicable

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Nil