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

Nepean Private Hospital

Penrith, NSW

Organisation Code: 12 03 14

Survey Date: 17-19 October 2017

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:

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

Table of Contents

About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Nepean Private Hospital
Orgcode : 120314

Survey Report

Survey Overview

Management and staff of Nepean Private Hospital presented well for the National Standards survey undertaken over three days from the 17th to 19th October 2017, demonstrating evidence of their achievements in improving care and services for patients. The hospital is well appointed, clean and aesthetically pleasing.

There is a well-integrated Healthscope and Nepean Private Hospital (NPH) clinical and corporate framework to support the delivery of safe and quality patient care. Management and staff clearly benefit from the Healthscope Corporate support through shared learnings and involvement of key staff from Nepean Private Hospital in Healthscope Cluster Working Groups which continue to focus on requirements of each of the National Standards. There is a strong culture of risk management and quality improvement.

Significant work has been undertaken in the last year under the leadership of the new executive team to equip managers and staff with the knowledge and expertise to meet activity and service delivery. It was also noted that the staff overall had made great efforts to ensure that all the criteria within the Standards were met. There have been significant challenges and changes over the past 18 months and there is evidence of effective and well communicated change management strategies to achieve sustainable change and improvements. There was consistent feedback from staff and VMOs that the Executive leadership is well respected and that the Executive has their confidence.

The surveyors were impressed with the high degree of teamwork and the integration of services for patients. Multidisciplinary teamwork in both fall and pressure injury prevention has resulted in injury rates below peer average is most impressive. Hand Hygiene rates for all staff groups and VMO continues to increase and currently is above the Healthscope Benchmark and national average.

Management and staff continue to demonstrate commitment to the process of increasing involvement of consumers. The consumer representatives are very active in communicating with patients and carers about patients' rights and responsibilities. Consumers are engaged in numerous activities to support patients and clients and importantly to identify and convey the views and needs of patients and carers. The consumer representatives demonstrated enthusiasm for their roles and expressed the view that they have an effective voice for consumers.

Overall, Nepean Private Hospital has performed well and managers and staff are congratulated on their enthusiasm, positive “can do” attitude and achievements demonstrated during this National Standards survey.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

There is an effective governance system in place for both corporate and clinical governance with organisation-wide risk and quality management systems. In this regard, Healthscope Corporate and Nepean Private Hospital (NPH) systems are well integrated with accountability and responsibilities defined and understood. Nepean Private Hospital strategic and business plans are aligned with Healthscope Strategic and Business Plan priorities.

There is an appropriate organisational structure with relevant committees, accountability frameworks and policies and procedures to actively manage patient safety and quality risks with an overarching Healthscope Corporate framework.

Risk assessment, risk management and continuous quality improvement are well integrated and evident in the culture of NPH. There is evidence of identification of issues, actions and outcomes in managing risk and improving quality across the organisation including conduct of clinical audits. Quarterly clinical KPIs are reviewed by the NPH Executive and the National Hospital Quality Committee. Shared Learnings are disseminated to support the identification and management of risks and quality improvements.

There is an organisation-wide Risk Register and Quality Plan that are actively monitored and actioned. Systems including incident reporting and management (RiskMan), critical system reviews, sentinel events management, audit program and Shared Learnings support patient safety and quality.

Staff are aware of their roles, responsibilities and accountabilities through position descriptions, orientation and ongoing training including mandatory and competency-based training. Staff receive training in understanding their roles and responsibilities in safety and quality with the National Standards included in the education calendar. There is a National Standards champion in each clinical area. The orientation program includes quality, risk, workplace health and safety, infection control and patient-centred care.

The concept of patient-centred care has been implemented to support the delivery of quality patient care. Elements include Clinical Handover, Patient Rounding, engaging patients and carers in care planning, and actively seeking patient feedback and input.

A patient-centred care model has been implemented and is currently represented by a range of policies including hourly rounding. It is suggested that a Patient Centre Care document be developed to communicate the key elements of Healthscope's Patient Centred Care model and philosophy to all stakeholders.

The Patient Centred Care Survey 2017 indicates that patient satisfaction regarding communication related to medicines could be improved and it is suggested that approaches to improve satisfaction be considered.

Effective data/information systems support quality improvements, risk management and decision-making along with the assessment of compliance against higher risk clinical policies and guidelines.

Clinical practice

A comprehensive range of evidenced based clinical guidelines are available electronically for staff to access on the Healthscope Internet (HINT) and use to inform policy and practice review.

Clinical Pathways are used predominantly in the Women's Health Unit (WHU) and include vaginal birth, elective and emergency caesarean section and a range of gynaecological abdominal surgery. The only other clinical pathways are the Coronary Angiography / PCI and Endoscopy pathways. Documentation of pathway variances was clearly evident. There is, however, an identified opportunity to strengthen the process of analysis of documented variances which were discussed with staff during survey. Pathways sighted were not well referenced to appropriate clinical evidence-based guidelines and/or best practice; however, the survey team was informed that this work has recently been undertaken and new revised clinical pathways were due for delivery from the printer at the time of survey.

A range of risk assessments are completed for surgical, medical and obstetric patients on admission and at regular intervals when clinically indicated. These include falls, venous thromboembolism (VTE), skin integrity, pressure injury, infection status, malnutrition and current medication history. Associated management plans were evident in patient clinical records.

The adult general observation chart and age specific paediatric charts are all designed for a track and trigger response, risk assessment and identification of deteriorating patients.

An effective system is in place for the escalation of care when there is an unexpected deterioration of the patient.

The design of the paper based clinical record allows for systematic audit of the contents against the requirements of the National Standards. The electronic K2 clinical record is printed and included in the patient clinical record post discharge. NPH audit results for an annual documentation audit to meet the legislative requirements and Australian Standards has identified ongoing opportunities for improvement. There is no clinical content audit currently undertaken; however, the survey team suggests that the current clinical reviews, analysis of variances within clinical pathways and patient incident and critical incident reviews could be expanded to provide the opportunity to reflect on the outcomes of care through a structure clinical content review.

Performance and skills management

Healthscope's policies and by-laws set out the requirements for credentialing/re-credentialing and defining scope of practice. The Corporate Credentialing System is used with scope of practice included in credentialing documentation. Credentialing and Scope of Practice approvals are through craft groups, the Medical Advisory Committee and the General Manager. Position Descriptions for all relevant staff include scope of practice. Credentialing and scope of practice details are available to all staff through WebPAS.

Clinical peer review for VMOs is included in the Clinical Governance Framework as per the By-Laws. Craft groups conduct clinical peer review with matters referred to the Medical Advisory Committee as appropriate. Monthly reviews are conducted with clinical managers to monitor performance against KPIs.

Appropriate committee structures including the Clinical Quality and Patient Safety Committee and the Medical Advisory Committee address practice and patient care issues. There is evidence that the planning and delivery of clinical services considers the clinical workforce capabilities, specialties and scope of practice currently available and future requirements; this includes consideration to the introduction of new services and procedures.

Appropriate systems support the delivery of safety and quality education. The system includes orientation, mandatory training, in-services training, training needs analysis and competency based training. There are a range of training and learning packages (ELMO) available to staff including the clinical workforce. Selected education and training information is placed on USB sticks to provide more flexible access to materials. This initiative has proven to be popular and successful with staff. The performance appraisal system also supports the identification of education and training needs. Training plans are developed as required and regularly monitored by the relevant manager with the staff member. Performance appraisal completion rate is 83% across Nepean Private Hospital. The Operations Committee is monitoring completion rates to ensure that this rate increases.

Mandatory training levels in some areas require improvement and improvement plans have been implemented. It is suggested that the methodology for recording mandatory training completion be reviewed to ensure accurate recording as well as integration of completion records.

Feedback from staff regarding quality and safety is achieved through a range of mechanisms including meetings and surveys. The 2016 Your Voice Counts survey and VMO/doctor surveys indicate some areas for improvement and action plans have been developed to address these. For example, staff indicated that more sharing of information regarding best practice approaches would be helpful.

Incident and complaints management

Appropriate systems and processes record, analyse, trend, risk rate and follow up incidents (including root cause analysis, critical system reviews and sentinel events review). RiskMan is used to record incidents and RiskMan training is provided for staff.

Committee structures and accountability frameworks support the identification and management of incidents including the Clinical Quality and Patient Safety Committee. Relevant KPIs and benchmarking of data is generated by Healthscope and includes Nepean Private Hospital. Shared Learnings are used to consider incidents/issues and take improvement actions as required.

The Work Health & Safety (WH&S) Committee and Health and Safety representatives are active in identifying, reporting and addressing workplace issues/incidents. There are WH&S representatives from across the hospital who conduct workplace inspections which are considered and actioned by the Committee.

There is an effective Complaints Management system with appropriate policies and procedures including escalation steps with all complaints escalated to the Executive level. Complaints are benchmarked and included in the Quarterly Quality KPI Report. There is feedback to staff on complaints through departmental meetings and the VMO Newsletter.

Information is provided to patients/carers on how to make a complaint. Patient Feedback forms are available throughout the hospital. The provision of online feedback from recently discharged patients is being piloted. This initiative is intended to give the patient time to reflect on their experience and give them time to provide feedback.

Open Disclosure training is mandatory for Nurse Unit Managers and clinical staff which is provided at orientation and eLearning modules. Executive support is provided to VMOs for open disclosure as required.

Organisation : Nepean Private Hospital
Orgcode : 120314

Patient rights and engagement

There is a Charter of Patient Rights consistent with the Australian Charter for Healthcare Rights which is displayed throughout Nepean Private Hospital. Brochures and information are available for patients and carers regarding their rights and responsibilities. Systems are in place to identify patients/clients at risk of not understanding their rights including the pre-admission process. Information is available in selected languages and interpreter services are available. Blood transfusion information brochures are available in different languages. The Hospital Coordinator maintains a register of interpreters as well as advocacy and support services.

There are effective processes to engage patients and carers in planning treatment including at pre-admission, through informed consent and ward based activity such as discharge planning and bedside handover. Patients are requested to sign a pathway or care plan after discussion with staff on admission.

A patient-centred care project has been implemented. The results of the most recent survey indicate that 80% of patients are satisfied with their communication with nurses and doctors; patients have indicated that they would like more information on medicines.

There is a corporate policy for Advance Care Directives. Advanced Care planning brochures are available for patients/carers. Patients/carers are asked about advance care directives on admission and relevant information included in the patient record. Recent audit results of Advance Care Directives indicate that the Medical Orders Life Sustaining Treatment (MOLST) form is not always completed. It is suggested that the Healthscope policy and procedure be reinforced to ensure that patient choices are known and met.

Consent for surgical procedures is monitored. Documentation audit results show compliance for consent for surgical procedures is close to 100%.

Appropriate policies and procedures are available including Confidentiality, Retention and Disposal of Health Information, Privacy, and Staff Code of Conduct to protect privacy and confidentiality of patient information; and to ensure that clinical records are available as required at the point of care including patient records management procedures and availability audits. Monitoring for duplicate records is conducted monthly. Computers are password protected and medical records storage is secure.

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM

1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

There is an effective governance and partnership structure at corporate and NPH level to engage and support consumers in partnering with NPH. The Healthscope Consumer Community Participation policy provides the framework for partnerships with consumers and the community. There are a number of Healthscope Consumer and Community committees and these provide consumer and community input from a corporate level.

NPH has three consumer representatives (one has recently left). Further representation is being considered and it is suggested that this consideration include the identification of opportunities from a diversity of input perspective. Consumer representative attend the Clinical Quality and Patient Safety Committee, and Infection Prevention and Control meetings. There is also a Consumer Participation Committee.

Consumers provide feedback on patient information and material. There is a Consumer Approved Publication program and Consumer Approved Stamp (CAP) on publications.

Consumer representatives are involved in service planning and delivery through a range of committees, working parties and focus groups at a corporate and NPH level. Consumer input and feedback was invited in the development of the most recent Strategic Plan.

Consumer representatives are provided with resources and support including orientation, training and job descriptions.

Consumer partnership in designing care

Consumers and consumer representatives provide input and feedback to the design of care through a range of activities including patient satisfaction surveys, focus groups and consumer attended meetings. The Patient Centred Care training package has been reviewed by consumer consultants. Consumer representatives attend all NPH staff orientation sessions.

Consumer partnership in service measurement and evaluation

The public have ready access to the safety and quality information about the service provided by NPH via the My Healthscope website, and My Hospitals website. The Healthscope Annual Report and a range of NPH foyer displays also provide relevant information.

Patient safety and quality data as well as patient feedback is analysed by consumers who are represented on relevant committees and working groups including the Clinical Quality and Patient Safety Committee and the Infection Prevention and Control Committee and participate in discussions regarding initiatives for improvement.

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems are well established for Infection Prevention and Control (IP&C) through a contracted service with Healthcare Infection Control Management Resources (HICMR). There is an extensive range of relevant HICMR, policies and procedures which are evidenced–based and/or best practice and compliant with The Australian Guidelines for Infection Control in Hospitals (2003). A broad range of HICMR evidence-based risk assessment tools are used to assess compliance with infection prevention and control standards, guidelines and legislation. Each tool has an associated action plan to address low compliance. The infection control program and compliance monitoring are overseen by the multidisciplinary Infection Control Committee (ICC). The ICC is chaired currently by either the HICMR consultant or the recently appointed Infection Control Coordinator. Membership of the ICC includes a consumer representative and both clinical and non-clinical department representatives. The infection control coordinator position is for 16 hours per week with the HICMR Consultant providing 16 hours per month. This committee meets four times per year and reports to the Executive Committee through the Quality and Risk Committee.

The review of the effectiveness of the infection prevention and control system against the ICC terms of reference, annual IP&C quality plan, corporate and clinical risk profile, ACHS Clinical Indicators and Healthscope KPIs is undertaken by the committee annually and reported to the Executive and Healthscope.

Managers and staff benefit from receiving shared learning opportunities through Healthscope IPC Cluster as well as receiving HICMR newsletters.

Surveillance data for ACHS IP&C Clinical Indicator (CI) and Healthscope IP&C KPIs are collected, trended, submitted and benchmarked. Results of CI and KPI and surveillance data are closely monitored and action taken, including critical systems review and staff education, to address poor and non-compliant performance as required.

Infection prevention and control strategies

A range of IP&C prevention and control strategies are undertaken including the Hand Hygiene Australia (HHA) monitoring program. HHA audit results indicate increasing improvement with the most recent hospital wide result being 93% which is above the Healthscope benchmark and national average. Nevertheless, the variability in audit results over the past three years indicates opportunities for continual improvement for all occupational groups.

Whilst a comprehensive workforce immunisation program is in place and all new employees are required to show evidence of compliance with Healthscope Policy 4.26, there has been poor compliance demonstrated by existing staff. A review of compliance rates for Cat A staff working in high-risk areas including Women's Health Unit and Operating Theatres identified a significant risk for newborn babies. The survey team was impressed with the rapid response by management to develop an appropriate action plan to ensure full compliance with the requirements of the Healthscope Policy to protect vulnerable patients. It is suggested that it will be important to evaluate the outcomes achieved at each of the defined milestones defined in the action plan to have 100% of all Cat A staff fully compliant with policy requirements.

Staff compliance with the use of personal protective equipment (PPE), sharps and clinical waste management is monitored closely and corrective action taken to improve compliance. This involves correct and appropriate use of face masks, eye protection and gloves as well as compliance with hospital policy to meet the Australian College of Operating Room Nurses (ACORN) standards in operating theatres (OT) and the Hybrid Cardiac Catheter Laboratory (CCL). There is also an identified need to continue to reduce the injury and exposure rate from both parental and non-parental exposures sustained by staff.

The safe use and management of invasive devices is closely monitored and overseen by the ICC. Specialty units such as CSSD, OT and CCL have separate lists of invasive devices held in each department that can be tracked back to a patient, and there is a process in place to track sterile invasive devices such as indwelling catheters and intravenous cannulas batch numbers through the stores department. Education in the use and management of invasive devices dovetails into aseptic technique education and competency assessment. Nevertheless, there has been a very slow response to the need to ensure that all relevant clinical staff have undertaken the required Aseptic Training and competency assessment. An action plan is in place to ensure that 100% of relevant staff complete the Elmo Learning Management Online (ELMO) training package and undergo competency assessment by end of November 2017.

Managing patients with infections or colonisations

Guidelines for standard precautions and transmission based precautions are available for all clinical and non-clinical staff as required. There is evidence of staff training and compliance annual monitoring of both standard precautions and transmission based precautions. Regular involvement of the Infection Control Coordinator and NUMs in overseeing the implementation of standard and transmission based precautions appears to occur; however, there was no documented evidence to support this regular activity. It is suggested that when a patient is identified as requiring transitional based precautions regular ad hoc observational audits of clinical and non-clinical staff compliance with transmission based precautions be undertaken and recorded to provide evidence of good compliance by staff as well as opportunities for improvement in current practice. Completion of the pre-admission patient information form ensures that patients with an infection or colonisation are identified to facilitate appropriate patient placement on admission and transfer. The WebPAS electronic system available in all clinical units including operating theatre, identifies patient's requiring transmission based precautions.

Antimicrobial stewardship

The Nepean Private Hospital (NPH) has an effective antimicrobial stewardship (AMS) program in operation, supervised by the Medication Safety Committee (MSC), with clear policies and procedures in place. Audit and activity reports are provided to the governance committees and feedback is provided to the clinicians. An annual antibiogram report is produced to guide the clinicians. Clinicians also have access to appropriate decision support tools along with support from a clinical pharmacist.

The clinicians have immediate access to appropriate guidelines, either electronically or in hard copy, on the use of antibiotics as well as support from infectious disease consultants and pathologists. The craft groups of specialists also have involvement in ensuring that the use of antibiotics concords with principles of best practice. There have been audits by the pharmacists of prescribing in both orthopaedic and urological surgery and there are plans to refine these activities to produce more clearly defined data. The NPH, as part of the Healthscope group, participates in cluster comparisons for benchmarking, as well as timely notification of trends of resistance, along with participation in meetings to discuss emerging issues of clinical management.

The hospital strongly supports the stewardship program, including an "Antibiotic Month" to promote the concept, as well as provide education to the clinical staff on the appropriate use of antimicrobial medications. Monitoring and feedback is seen as an important task for the MSC with its activities now combined with those of infection control.

Cleaning, disinfection and sterilisation

Policies and procedures for environmental services are available to ensure the principles of infection prevention and control are practiced in cleaning, waste management, linen transportation, processing and storage, air handling system, cooling tower management and legionella detection in water systems, pest control and preventive maintenance and quality testing of steam generators, sterilisers and washer disinfection maintenance. Annual risk assessment audit conducted by HICMR result in a compliance report and action plan to address areas of non-compliance. Environmental clinical cleaning schedules as well as environmental cleaning schedules are well established. Current material data sheets are readily available for to staff.

Cleaning schedules were evident in all clinical utilities and storage areas. Surveyors observed the appropriate use of neutral detergent wipes for cleaning patient related medical equipment in all areas of the hospital. The hospital presents as clean and relatively uncluttered.

The surveyors observed the Operating Theatre Suite, Hybrid CCL and Endoscopy flows to be appropriate with identified areas for improvement in Central Sterilising & Supply Department (CSSD) including the need to redesign the areas for receipting and reprocessing loan instruments. The practice of covering all used surgical/ endoscopy instrumentation prior to being transferred into the CSSD cleaning area is appropriate. An external sterilisation consultancy has been undertaken, the results of which have guided the development and planning for the refurbishment of the CSSD department to meet the requirements of AS/NZS 4187:2014 which is due for completion in 2018 as per the sighted implementation plan.

Significant work has been undertaken to improve the effectiveness of available space in the Endoscopy area since the last survey. The purchase of 18 new scopes has further enhanced this service. Whilst the cleaning sinks remain still too close to the disinfection machines, staff demonstrated how the risk of cross contamination between dirty and disinfected scopes was mitigated. The storage area for endoscopy has been identified as an area for upgrade along with the need to replace the existing Glutaraldehyde Soluscopes.

The majority of clinical ward areas have recently had significant work undertaken to improve the storage of general and sterile consumables through more appropriate storage systems. The survey team suggests that where possible the wire basket storage system rather than flat plastic storage systems be installed to enhance the effectiveness of cleaning and the integrity of the sterile consumables.

A manual tracking system is used to trace instruments, trays and scopes to individual patients. The integrity of the sterilisation is rigorously monitored in accordance with AS/NZS 4187:2014. The existing three sterilisers are twenty years old. There is a plan to replace all three sterilisers in the planned CSSD refurbishment. Staff awareness of Creutzfeldt-Jakob disease (CJD) infection in the management of instruments and trays for neuro-surgical patients was evident.

Staff allocated responsibility for the decontamination, disinfection and /or sterilisation in CSSD are appropriately trained and assessed annually.

Communicating with patients and carers

Appropriate brochures are available for patients and families on the management and reduction of healthcare associated infections, together with signs prompting visitors to use provided hand gel. The “My Healthscope” website provides public access to NPH Clinical Outcome performance for Infection rates and Hand Hygiene compliance rates of staff and doctors. Patient and consumer feedback on the usefulness of provided information is sought and used for improvement.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

Aseptic technique annual training has been completed by 89% of relevant clinical staff whilst 79% of relevant staff have completed the annual competency assessment in AT. An action plan is in place to have 100% of relevant staff trained and competency assessed by 30 November 2017.

Accordingly, this action is rated as SM at the transitional level.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

A gap analysis against the requirements of AS\NZS 4187:2014 and related implementation plan to address identified gaps in the Central Sterilising and Supply Department (CSSD), Operating Theatre (OT) and Endoscopy has been completed and was provided to the survey team. Planned completion dates for Endoscopy is due for completion in 2020 whilst the CCSD/ OT redevelopment work is planned to be completed by January 2019.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The Nepean Private Hospital (NPH) as part of Healthscope has a combination of corporate and local governance for medications to ensure that the hospital meets all national and jurisdictional requirements. Benchmarking is undertaken through cluster arrangements and the data is provided to staff for continuing education. At the local level, there are several clinical governance committees that mange the medication systems, as well as involving the speciality craft groups for advice along with specific advice from consultants as required - particularly in the area of anti-microbial stewardship.

A range of medical and surgical services are provided at NPH, with a high dependency / intensive care unit (HDU/ICU) as well as day procedures and some paediatric services. As a result, medication safety is recognised as a key responsibility, with mandatory staff training (Med-Safe), shared learning bulletins from the corporate clusters along with competency reviews required for all aspects of medication management, including the administration of IV medications - basic maths calculations for doses and infusion rates. Alerts for any newly introduced medications are discussed at unit meetings.

All authorisations for medications prescriptions by a medical officer who undergo credentialling audits every year to ensure that their authorities are current. Regular audits of the prescribing system are undertaken and the clinical governance committees review the medication management system and institute changes as required through the Medication Management Action Plan. The NPH has a clinical pharmacist on-site who provides support to the nursing and visiting medical officers as well as playing a key role in clinical governance and supervising high risk medications. The on-site medical officers (CMO) are required to complete the National Prescribing Service modules and maintain their training. Support tools and references for prescribing are readily available to the medical staff and to the nursing staff for information.

Any adverse medication reactions, incidents or near-misses are entered into the RiskMan software, then reviewed by the various clinical governance committees, with appropriate actions initiated and that information flows back to staff though unit meetings and emails as required.

There is regular auditing and assessment of the medication management system and benchmarking is managed through the cluster comparisons, with targeted education and training as required through the medication management action plan. One recent audit showed that 80% of telephone orders were signed within the required time frame of 24 hours. It is suggested that the hospital continue to work to improve the rate of satisfactory completion of telephone orders by the medical officers within the required time-frame.

Documentation of patient information

Every patient has a medication review and documentation completed upon admission, including asking patients about complementary medications, with a medication chart created immediately. Patients are specifically asked about adverse drug reactions or allergies, with notation made on the medication chart and in the medical record and if in the affirmative they also receive a red identification band. Audits are conducted annually for compliance, with corrective actions initiated when necessary. Nevertheless, the audits show that some documentation does not have an active entry of "no known allergies", which is considered a necessary requirement to ensure that the patient has been asked the question about allergies or adverse reactions. It is suggested that the NPH ensure that 100% of medication records includes an active entry in the allergies / adverse reactions section.

Patients with complex regimes or high-risk medications are placed on a medication management plan, which triggers a review by the clinical pharmacist. The documentation is regularly reviewed and audited for compliance and completeness. Patients on high risk or unusual medications, or known adverse drug reactions, are identified by a medication alert sheet which is at the bedside and in the medical record.

At the time of discharge, patients and families receive a comprehensive list of medications and are provided with consumer information sheets if they are on a new medication. The clinical pharmacist is also involved with those patients being discharged or transferred on a high-risk medication. This process is regularly audited and reviewed by the clinical governance committees for quality improvement.

Medication management processes

Alert sheets are created for all high-risk medications, known adverse reactions or unusual medications and these are available at the bedside along with the medication charts. Medication safety audits show a good improvement in compliance since the last accreditation. Some high-risk medications are stored in the patient's locked drawer however these are not clearly identified as being high risk medications. It is therefore suggested that any high-risk medication that is stored at the patient's bedside be labelled with a coloured sticker to indicate its high-risk status.

Staff strive to have uninterrupted medication rounds by wearing identification vests. Medication management issues are discussed in regular unit meetings. All prescribing is undertaken by the medical staff who have ready access to contemporaneous prescribing tools in both electronic and hardcopy formats.

The clinical pharmacist works closely with the nursing and medical staff to manage high risk medications, patients on unusual medications or those who have complex regimes of medications. Any staff involved in a medication incident or near-miss is asked to undertake a self-reflective process as part of their education. The RiskMan system provides the clinical governance committees with oversight of any problems with medication management and they take appropriate action.

All temperature sensitive medications are stored in refrigerators that have daily temperature monitoring recorded, Audits are conducted and changes implemented as required. Corporate and cluster data is used for comparison and quality improvement.

High risk medications are identified when in use and the pharmacist is alerted when any new one is introduced for a patient. An infectious diseases physician provides advice if any high caution antibiotics are ordered. High dose potassium is securely stored in the HDU/ICU but it would be best practice to have a log to track its use. It is therefore suggested that there is a log established of the use of high dose potassium.

Any unwanted medications are placed in the standard medication disposal bin (RUM), which is located in the locked medication cupboard, then sealed and disposed of by the pharmacy team.

Continuity of medication management

All patients receive education about changes in medications, including the substitution of brand-name as required. The clinical pharmacist is involved in educating patients with complex medication regimes or high-risk medications, as well as educating staff and reviewing medication management plans.

All patients receive a contemporaneous list of medications at the time of discharge. The clinical pharmacist is involved in the discharge process when high-risk medications are prescribed as well as with any patient who has a medication management plan. Regular audits and chart reviews are conducted with the medication safety committee reviewing the data and undertaking education or changes to processes if required.

There are clear policies and procedures to follow when a transfer of care is undertaken, which includes the inclusion of a list of current medications as part of the checklist for transfers. Regular audits are performed by the medication safety committee to check compliance with the procedures and amendments made as required.

Audits of the transfer processes include a check for a list of current medications, so that the medication safety committee and other clinical governance committees can analyse the effectiveness of the process and provide education and training as required.

Communicating with patients and carers

All prescribing is undertaken by the medical officers, who provide patients with information concerning options, benefits and risks of medications. The clinical pharmacist is actively involved with patients, who are already on, or commencing, a high-risk medication. Nursing staff provide consumer information sheets to patients who are on a new medication, at the time of discharge.

Staff have quick access to consumer information sheets for medications at the point of care, through access to several online medication information sites (e.g. MIMS) as well as the Healthscope pharmacy site. There is a DVD available for patients who are discharged on Clexane therapy. Patient surveys are conducted and the most recent data (April-June 2017) shows that patients rated 87% good/very good for the question concerning medication information at discharge. As a result of an increasingly diverse ethnicity of patients, the NPH has brochures in the commonly encountered languages to explain the medication discharge process.

The NPH has an active consumer group who provide feedback on the appropriateness of the medication information. Surveys of patients are collated and reviewed by the medication safety committee to improve the services.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Nepean Private Hospital
Orgcode : 120314

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The Healthscope patient identification system is well established and closely monitored. The four required patient identifiers are used in WebPas to produce patient labels and armbands. Each clinical area has a Zebra WebPas linked machine that producers the black on white patient identification arm band and the black on red band identification band for patients identified as having an alert. On arrival at the hospital reception, the patient front sheet admission details are confirmed by administrative staff and the patient is guided to either the Day Surgery or Women's Health Unit (WHU) at which point the identification arm band is produced and attached to the patient. Annual Audit results of compliance with the patient identification system consistently indicate 100% compliance since 2015.

The incident reporting system RiskMan is used to monitor incidents of failure to adequately identify patients on admission, prior to treatment including medication administration, at the commencement of bedside clinical handover, during transfer to and from ward to diagnostic and surgical procedural areas and as part of team time. Evidence sighted in the February 2017 incident reports included one patient identification incident and one clinical handover incident.

Processes to transfer care

The Healthscope patient identification and matching system is well established and regularly reviewed as part of the structured clinical handover, transfer and discharge processes. Any patient requiring transfer to the public hospital have a documented transfer form completed prior to being escorted by a NPH staff member who completes a clinical handover to the receiving team.

Processes to match patients and their care

Healthscope policy 2.15 identifies all events that require procedure matching including correct patient, correct procedure, correct site, as part of the Team Time Out in operating theatre, endoscopy and angiography. The survey team observed team time out in the operating theatre to be well structured, clear and concise process involving the patient and all members of the surgical team.

Healthscope shared learnings continue to provide staff with value information to avoid incidents related to patient identification.

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation : Nepean Private Hospital
Orgcode : 120314

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Healthscope Policy 8.18 identifies the situations requiring clinical handover. The ISOBAR (identify, situation-observations-background-agreed plan-read back) communication tool is used in all nursing clinical handover situations and retained in the patient clinical record. CMO to VMO clinical handover was observed in the HDU during survey to be clear concise and well documented in the patient clinical record. Whilst there is a requirement for CMO clinical handover with each change of shift, this occurs verbally but is not documented. It is suggested that an appropriate process for all CMO handovers be documented, dated, signed by both CMOs and the record retained for a predetermined period.

Clinical handover processes

Bedside handover is undertaken at least once every 24 hours at change of shift in all clinical units.

Annual audit results of clinical handover are routinely reported and reviewed by the executive.

Risks associated with clinical handover are included in the risk register. All incidents are trended and reported to the executive, the Clinical Patient Safety and Quality Committee and as a KPI to Healthscope. Incident trend data for the 2014- 2016 indicated opportunities for improvement. Similarly, audits of clinical handover indicated poor compliance across the majority of clinical units. Accordingly, a Documentation and Clinical Handover Project has been commenced and at the time survey had reached the 6th stage of a well-constructed strategic project plan to improve the effectiveness and appropriateness of clinical handover compliance with policy. At the commencement of this project the range of compliance across all five clinical units was significantly low and variable (36 – 93%); post implementation of planned actions, including educational strategies and compliance with policy, had increased significantly in all five areas to a range of 86-100% compliance. Stage 7 of this impressive project involves three and six monthly scheduled evaluation of ongoing compliance in clinical handover and the commencement of a clinical content documentation auditing program. The survey team acknowledges the significant work undertaken to date and encourages the project team to fully complete this important project through ongoing monitoring and evaluation into the foreseeable future.

Patient and carer involvement in clinical handover

Healthscope policy for clinical handover includes patient and where relevant their carer's involvement. Audit results for the last three years indicate that this an identified area for ongoing improvement which is currently being addressed in the Documentation and Clinical Handover Project referred to above.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

The NPH as part of Healthscope has corporate overarching policies and procedures for the management of blood and blood products, which are consistent with the national guidelines and NSW Health requirements. There is a Nepean Private Blood Transfusion Committee and a Nepean Private Anaesthetic Committee that provide local oversight as well as ensuring that education of staff is completed, with an annual competency check. Midwives need to complete a specific Post-partum haemorrhage (PPH) module. The use of the policies and protocols is monitored and education and/or retraining is undertaken when required. Audits of medical records are performed by the transfusion committee to ensure that the prescriptions of blood conform to current guidelines.

The majority of transfusions managed at the NPH are related to post-operative situations (HDU/ICU) with relatively few elective transfusions performed. It is acknowledged by the surveyors that present staff training involves mock scenarios, but it is important that the NPH be aware of the risks and ensure that appropriately trained staff are available in the general wards when required. It is suggested that the NPH conduct a risk assessment of the number of elective transfusions with respect to the availability of experienced staff.

Any incidents are reported through the RiskMan system and reviewed by the Blood Transfusion Committee and other clinical governance committees when required, with any remedial actions sent to staff for attention. All adverse reactions are first reviewed by the committee and the reports are then re-assessed by the Clinical Quality and Patient Safety Committee, the Medical Advisory Committee and the specialty craft groups with communication back to the ward staff being a priority. Cluster reports are used for benchmarking as well as staff education. The information is also used in Healthscope's national transfusion committee, which participates in state and national management reviews.

Documenting patient information

The NPH has recently introduced a new form to detail the patient's transfusion history, which is then compared with any available history provided by the pathology company (the sole provider of blood to the NPH). The identification sequence for all blood or blood products is recorded in the patient's medical record. An annual audit of compliance with the policies and procedures is managed by the transfusion committee, with results reviewed by other governance teams as well and used to formulate education and training for improvement. All clinical staff have to undertake annual electronic blood-safe training, as well as mock scenarios, and this training includes the ancillary staff who may be required to collect blood from the neighbouring public hospital. Within NPH, all blood is collected from the blood refrigerator by an RN. Any incidents are reported into RiskMan for review by the clinical governance teams. Any adverse reactions are fully documented in the patient's record and then always reviewed by the transfusion committee with reports going to senior governance committees and the specialty craft groups as well as the pathology company that supplied the blood. Directed training and education for staff is instituted where necessary. Families and carers are also given advice as to what signs or symptoms to watch for when accompanying their family member.

Managing blood and blood product safety

All blood that is delivered to the NPH is placed in the single blood refrigerator and recorded in the approved register with its removal also recorded. The temperature of the refrigerator is continually electronically monitored, as well as physically checked daily and any move outside the approved temperature range will trigger an alarm. Blood is always transferred in approved temperature control bags. There is regular auditing of all these processes to manage the refrigerator and the blood stocks and any retraining is commenced if required. All transfusion practices and protocols are in accordance with the national transfusion practice guidelines, with regular audits conducted by the transfusion committee to ensure compliance. The data is shared with the cluster meetings to benchmark performance. Any incidents are reported into RiskMan and the transfusion committee reviews the information and creates an action plan if necessary. Reports are sent to the other governance teams when required for their input.

Control of wastage of blood and blood products is seen as a high priority for the NPH, with monthly reports sent to the transfusion committee, the Medical Advisory Committee and the speciality craft groups. It was recognised that blood could be conserved by simply educating the surgeons to ask for a "group and hold serum" with the pathology laboratory, rather than order a delivery of blood that is most likely to be unused. This has resulted in a significant drop in wastage of blood.

Communicating with patients and carers

Patients are given information about blood transfusion, or the use of blood products, from their treating physician and the nursing staff, along with brochures and other resources, that explain the benefits and risks of a transfusion. These brochures are available in several languages to meet the ethnic diversity amongst the patients. Brochures have been reviewed by the consumer representatives with advice received on their effectiveness and understandability. Families and carers are invited to participate in the discussions and an interpreting service can be provided if necessary. All questions and concerns are addressed as best as possible.

Obtaining consent for a transfusion is an important process, with a dedicated blood transfusion consent form in use for elective transfusions. It is accepted by the surveyors that there are occasions where a patient will receive a blood product on a regular basis and, in that circumstance, annual consent would be satisfactory provided that there is no significant change in the patient's condition. Refusal of transfusion is acceptable, with steps taken to ensure that the patient, family or carer is making an informed choice.

For elective procedures that are not expected to involve a transfusion, there remains a need to obtain consent beforehand in case the situation arises and the surveyors found that this consent process was not fully completed on quite a number operative consent forms reviewed. It is a matter of fact in health care that a seemingly innocuous procedure can result in the need for blood, so it is very important that the patient has discussed this matter with the specialist beforehand and that this discussion is confirmed by the appropriate indication on the consent form. It is therefore suggested that the hospital work with the VMOs to ensure that consent for transfusion is clearly documented on the operative consent form.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

A very proactive focus is evident throughout NPH for the prevention and management of pressure injuries. Governance and systems are underpinned by evidence-based guidelines that inform the development of both Healthscope policies and local procedures. A Pressure Risk Assessment / Screening Tool for adult inpatients is used on admission and throughout the patients stay as required. A multidisciplinary Preventing and Managing Pressure Injuries working party has been responsible for overseeing effective governance across the organisation up until the beginning of 2017. It is suggested that consideration be given to the process of ongoing monitoring and review of pressure injury prevention and the ongoing opportunity for a multidisciplinary group to oversee this important aspect of patient care.

All incidents of patient pressure injury are required to be recorded in the RiskMan reporting system with each incident required to be investigated and responded to according to policy requirements. There has been a significant improvement in the rate of hospital acquired pressure injury in recent years compared to 2014 when 46 hospital acquired pressure injuries were recorded. The last stage 2 pressure injury was reported in June 2016. In July 2017 one pressure injury was reported, indicating an ongoing need for continuous improvement in pressure injury prevention.

Preventing pressure injuries

On admission, a Waterlow Risk Assessment is documented in the patient clinical record. Patients identified as being at risk of sustaining a pressure injury have a management plan completed. This management plan is located on the reverse side of the Waterlow Scoring tool. The prevention plan includes referral to the appropriate allied health team, and the provision of appropriate equipment and clinical care based on the identified Waterlow Score prevention strategies.

Audit results indicate that patients are screened and assessed on admission and a management plan completed for all patients identified as being at risk.

Appropriate equipment includes the use of memory foam mattresses for patients with a Waterlow score of 20 or below and air mattresses for patients with a higher than 20 Waterlow score. Hourly rounding and turning of high risk patients is charted.

Ongoing Education and close monitoring of staff capability to comply with policy and best practice is evident.

Managing pressure injuries

Management of both pressure injury and wounds is consistent with Pan Pacific Clinical Practice Guidelines. A wound management assessment and ongoing care form HMR 7.12 is used to document all wounds. Clinical staff appeared to be well informed about pressure injury management and wound management.

Communicating with patients and carers

Specific written information including the Healthscope Pressure Injury Prevention brochure is available for patients on admission and discharge as required. Patient feedback indicates a high level of satisfaction with the information provided to them.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

NPH has an overarching corporate Quality and Safety plan which underpins its activities in clinical care and provides cluster support for clinical activities. A range of policies and procedures are in place, with the NPH Resuscitation Committee providing first line management on-site in anticipation of a deterioration of a patient. Policies are aligned with the national and state requirements. All rapid response calls are reviewed in depth, along with a review of incidents of unexpected patient deterioration that are logged into RiskMan and considered by the governance teams. Any cardiac arrests or unexpected deaths are reviewed fully by the Resuscitation Committee as well as reported to the Clinical Quality and Patient Safety Committee and may be sent to the Medical Advisory Committee plus the various specialist craft groups as well, for consideration. Feedback is provided to the clinical workforce and often individual counselling is given to those staff directly involved in the unexpected death.

Response systems have been included in mandatory training, as well as competency reviews being undertaken, sometimes using a scenario format, to present the information in a more accessible format; the new rapid response policy was introduced in this manner. Training is also delivered through mock scenarios as well as eLearning. Feedback from staff about the response systems has been sought by the Resuscitation Committee and suggestions have been incorporated, so that the clinical staff are working to develop a comprehensive flow-chart for care of a deteriorating patient, aiming to bring together the various activities into one system.

Recognising clinical deterioration and escalating care

The NPH uses standardised observation charts, including appropriate charts for paediatric and maternity patients. The observational criteria to trigger escalation of care, or even a rapid response, are clearly indicated on each chart. The various clinical committees oversee the use and effectiveness of the observation charts, through audits to measure compliance and then develop educational activities. The Resuscitation Committee and the Clinical Quality and Patient Safety Committee review audits of records with the results reviewed by the specialist craft groups and the Medical Advisory Committee when appropriate. Results are also benchmarked through the Healthscope clusters and the results are sent back to the clinical staff through meetings.

The organisation has a range of educational programs for the clinical staff to improve the standard of observations. With a consistent number of student nurses in the wards there is specific orientation and training on the correct use of the charts.

The NPH has emergency call buttons in all clinical areas, including bathrooms and lounges, along with display signs for family and carers. The criteria for calling a rapid response are clearly displayed in the units, plus the staff have scenario training for escalation of care. At handover, staff routinely include information about any patients of concern. Further, the hospital is planning to deliver an educational video on how to escalate care, through the internal TV channels, based on the REACH (Recognise, Engage, Ask, Call, Help) initiative for families and carers. There are brochures explaining to families and carers the way to escalate care that are available in several languages, to match the cohort of patients. It is suggested that the brochures in other languages be more widely promoted for staff awareness and made easily available to staff for distribution.

All rapid response calls are reviewed by the Resuscitation Committee, plus a review with family members is undertaken within 24 hours of the event. Regular audits of the processes and procedures are undertaken with the outcomes sent back to staff through unit meetings and educational activities if required.

Staff education and training include mandatory components covering the escalation of care and the REACH principles. Healthscope has a shared learnings report that brings in reports from the hospital clusters of incidents or near-misses, to add to the organisation's own risk reports. Regular audits and monitoring of events is undertaken, then used to direct the education programs.

Responding to clinical deterioration

Healthscope provides the corporate policies, whilst the Resuscitation Committee of NPH regularly reviews and amends policies and procedures for the rapid response system to align with local conditions and clinical activities. All emergency calls are reviewed by the Resuscitation Committee, to examine the effectiveness of the systems and responses. Issues of significance are further reviewed by the specialist craft groups and the other clinical governance committees, with changes to policies and procedures made as required.

Training in basic life support (BLS) is mandatory for all staff, including ancillary ward staff, with scenario training as well. However, the rates across the organisation are below that expected, albeit at 80% of the electronic training and competency at 90% completion. The hospital has recognised that there are time constraints for some staff, so training will be provided on a weekend for those particular staff.

Advanced life support (ALS) training is provided to staff to ensure that appropriately trained staff are always available for rapid response calls. There is a trained medical officer available 24-hours onsite, plus intensivist medical practitioners who are in close proximity.

Communicating with patients and carers

The organisation has adopted the REACH program for families and carers to assist them in escalating care. It is planned to have the internal TV channels broadcast an informative video as well. Recognising the broadening ethnicity of patients, the hospital has a range of brochures covering how to escalate care in several languages available. Signs are placed in the rooms and patient lounges as well. The cohort of patients at this hospital are generally relatively healthy. Nevertheless, there is a system in place to manage advance care plans when they are appropriate. In the event that a patient presents with advance care plans or treatment limiting orders, they are reviewed with the patient by the medical officer and then recorded in the patient's clinical record. When such a plan is implemented, staff are supported through the process to recognise that these documents present the patient's specific wishes and, as such, are to be honoured.

All emergency calls are reviewed by the Resuscitation Committee to assess effectiveness, plus families and carers are surveyed within 24 hours of an emergency call. Unit managers review escalation processes when it does not involve an emergency call. The REACH program is also monitored by the clinical committees for effectiveness and suitability. The organisation reviews its own performance data from RiskMan, patient and family feedback, benchmarking within the clusters and the deliberations of the governance committees, aiming to improve the system for families to escalate care.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

Training in basic life support is mandatory for all staff, including ancillary ward staff, with scenario training as well. However, the rates across the organisation are below that expected, albeit at 80% of the electronic training and competency at 90% completion. The hospital has recognised that there are time constraints for some staff, so training will be provided on a weekend for those particular staff. Accordingly, this action is rated as SM at the transitional level.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

There is a Healthscope Patient Falls Prevention and Management policy and NPH is fully compliant with this policy.

Falls incidents are reported on the RiskMan system, data is trended and reported to the Clinical Quality and Patient Safety Committee.

Falls data is included in the Quarterly Quality Report which is considered by the Executive and the Medical Advisory Committee.

Screening and assessing risks of falls and harm from falling

Falls Prevention and Management policy is available to all clinical staff on the Intranet. Falls education is provided to staff by eLearning (ELMO). The admission risk screening tool (Falls Risk Assessment Tool - FRAT) includes screening questions on falls risk. Risk assessments are conducted on all patients on admission, after surgery and throughout the episode of care. Falls risk assessment is part of clinical handover. Falls information is available at the bedside.

FRAT is used throughout NPH and its use is monitored. Recent audit indicates a high level of compliance for completion of the FRAT (close to 100% across NPH completed within 24 hours of admission). Audits of patients post fall are conducted with follow-up actions as required with reporting to the Clinical Quality and Patient Safety Committee.

The Risk Register includes falls and actions. Falls categorised as sentinel events are reported to the National Risk Manager for actioned to be determined. Improvement initiatives are included in Quality Plans.

Preventing falls and harm from falling

There are appropriate tools for the documentation of falls prevention and harm minimisation plans. Some good examples of reducing harm from falls include patient information brochures on falls and “A Step Ahead of Falls” is provided at orthopaedic pre-admission education sessions and available to all patients the bedside, grip socks, gait aids tag, and implementation of the Orange Strategy (currently being trialed with planned roll-out to all units). Ward areas have a good range of equipment to reduce the risk of patient falls including lifting equipment and walking aids.

There is a Falls Prevention Cluster that has developed policies and tools (in accord with best practice guidelines). Medication chart reviews are conducted for patients at high-risk of falling.

Falls Huddles (conducted within 24 hours of the fall) have recently been introduced to discuss falls with staff, the patient and the carer.

Communicating with patients and carers

A range of falls risk material is available throughout the hospital and in the bedside directory.

Patient/carer brochures are provided. Information can be provided in other languages as required.

Consumer representatives have provided input to the fall information/brochures.

Care plans provide evidence that falls prevention plans are developed in consultation with patients and carers. The Falls Huddles is considered to be an effective way to engage patients and carers in discussion of falls risk and prevention.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Nepean Private Hospital
Orgcode : 120314

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM

1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

	role		
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved	SM	SM

- waste management within the clinical environment
- laundry and linen transportation, cleaning and storage
- appropriate use of personal protective equipment

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and	SM	SM

	comprehensive list of medicines and explanation of changes in medicines		
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their	SM	SM

carer in clinical handover are in use

Blood and Blood Products

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

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

Documenting patient information

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Preventing pressure injuries

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

Managing pressure injuries

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

Communicating with patients and carers

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service	SM	SM

	organisation		
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation : Nepean Private Hospital
Orgcode : 120314

Recommendations from Current Survey

Not applicable.

Organisation : Nepean Private Hospital
Orgcode : 120314

Recommendations from Previous Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.1 The clinical workforce is trained in aseptic technique

Recommendation: NSQHSS Survey 1014.3.10.1

Recommendation:

Ensure relevant staff undertake ANTT training and competency assessment in accordance with the action plan.

Action:

Nepean Private Hospital purchased the ANTT-UK training package. This was rolled out through clinical areas in August 2013.

ANTT training has been introduced in 2015 to new hospital staff at facility orientation within the Infection control presentation and via ELMO electronic education.
In 2015 all clinical nurse educators have been trained in ANTT and have completed ANTT competency assessment.

Work has begun in all clinical areas to up skill new staff in this area and complete competency assessments on clinical nursing staff.

Education has been added to mandatory training calendars for staff to attend in 2015. With this, and assistance of the staff development manager and infection control coordinator, education will now begin to improve training in this area. ELMO education compliance for ANTT in 2016 currently stands at 61% compliance as of 31st August. In 2017 ANTT education is available on ELMO and Competencies on ward continue
ANTT auditing has begun in areas of wound care, IV prep and administration and IV cannulation. Auditing results have indicated an average compliance of 86-97% across all areas.

Completion Due By: Dec 2017

Responsibility: Simon Rodger/Jill McEvoy-Williams

Organisation Completed: Yes

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

Whilst there has been some progress in addressing the intent of this Action, there is not yet 100% of relevant staff who have completed the required annual training and competency assessment. An action plan is in place at the time of survey for this to be accomplished by end of November 2017. Whilst this recommendation has been closed, there is a new recommendation made as this Action is still only met at the transitional level.

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Standard: Clinical Handover
Criterion: Governance and leadership for effective clinical handover
Action: 6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols

Recommendation: NSQHSS Survey 1014.6.1.2

Recommendation:

Review procedure and practice for provision of discharge reports by surgeons to patients' general practitioners, with copies being retained in hospital clinical records, with the aim of improving clinical handover on patient discharge.

Action:

Post survey a letter was distributed to all VMOs advising of protocol as per Healthscope bylaws to provide discharge summaries to the facility for patients whom stay in the facility for greater than 24 hours, this was also discussed at Nepean Private Hospital Medical Advisory Committee meeting in April 2015, And August 2015., and is now regularly mentioned at craft groups and MAC.

Regular auditing of patient files is now conducted every 3 months, this has not previously been attended, with data then discussed and presented at Medical Advisory Committee meeting. Compliance in March 15 indicated a 11% compliance and in July 2015 increased to 30%. this still indicates a decrease in compliance from last survey in October 2014.
Regular quarterly auditing continues in 2016 to assist with improving compliance in this area. As of June 2016 compliance is at 48% compliance, June 2017 Compliance is now at 72%

Auditing in this area is also captured within our Annual documentation audit

	2014	2015	2016	2017
ICU Discharge summary	0	37.5%	61.27%	
Medical/Surgical Discharge Summary	50%	38.60%	48.12%	
Obstetric Discharge Summary	0%	0%	28.46%	
Neonatal Discharge Summary	0%	0%	34.68%	

A new Healthscope ICU discharge summary has been developed in 2017 and newly released in August 2017 for printing. This form will be rolled out in ICU in Sept 2017.

Completion Due By: Aug 2017

Responsibility: Simon Rodger/Jill McEvoy-Williams

Organisation Completed: Yes

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

Significant work has been undertaken to address the intent of this recommendation since the last survey, with increasing results of compliance from all craft groups. Discussions during the survey with members of the Medical Advisory Committee indicated an increased awareness of the medico-legal importance of ensuring that there is documented evidence of discharge reports by the VMO provided to the patient's general practitioner along with a copy saved in the patient's hospital clinical record.

At the time of survey, 72% of all patient clinical records had a copy of the VMO discharge summary or letter of discharge that had been sent to the patient's general practitioner.

The survey team acknowledges this overall improvement; however, suggests that there remains an ongoing need to continue the frequent monitoring and ongoing improvement to ensure compliance with Healthscope Policy and By-Laws.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Recommendation: NSQHSS Survey 1014.9.9.3

Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Action:

Nepean Private Hospital has introduced whiteboards within patient rooms of clinical ward areas. Emergency information has been placed on these whiteboards for patient information on emergency procedures. Inside rooms next to all emergency buttons, signs have been placed advising patients and families on procedure for initiating a medical emergency. Information has also been placed into the patient information booklet provided to patients on admission.

A consumer representative is available at Nepean Private Hospital, part of the consumer representative role in 2015/2016 is to assist in education of patients and families on initiating a medical emergency and surveying whether they understand the information provided to them. Patient and carer escalation call surveys have commenced in 2015 and continued in 2016 data is presented at clinical quality & patient safety committee by consumer representative. These surveys initially had a baseline compliance of 0% in January 2015, where surveys indicated patients and carers were not informed of medical emergency procedures, protocol for escalating a medical emergency and where not informed of information in patient compendiums, whiteboards or shown signs in rooms on admission on how to escalate a medical emergency.

As of June 2016, compliance is now at 75% showing a marked improvement due to education and changes implemented due to upgrade of patient compendiums, and new signage in rooms. 2016 has also allowed us to review our RRS escalation system. This year we have had two medical emergencies that were initiated by patient relatives. This found issues with our system and review has begun to develop and introduce a new program. An RRS working party has been put into place for this process.

The CEC REACH program has been rolled out in Aug 2017 - with signage now displayed in each patient room. Staff have been educated and a plan has been developed for future review and follow up of this program. Patient and Family carer surveys have commenced on the REACH program. Information on REACH has been added to our website for patients whom attend e bookings and will be added to the next run of our patient bedside information booklet.

Completion Due By: Aug 2017

Responsibility: S Rodger/Jill McEvoy-Williams

Organisation Completed: Yes

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

The organisation has adopted the REACH program for families and carers to assist them in escalating care. It is planned to have the internal TV channels broadcast an informative video as well. Recognising the broadening ethnicity of patients, the hospital has a range of brochures covering how to escalate care in several languages available.

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Combined

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

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Surveyor - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : Nepean Private Hospital
Orgcode : 120314

Combined

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

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