NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Final Report

The Victoria Clinic

Prahran, VIC

Organisation Code: 221780
Health Service Facility ID: 101121
Assessment Date: 19-20 July 2022

Accreditation Cycle: 1

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

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Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

The Victoria Clinic (TVC) underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 19/07/2022 to 20/07/2022. The NS2.1 OWA required two assessors for a period of two days. The Victoria Clinic is a private health service. The Victoria Clinic was last assessed between 20/11/2018 – 21/11/2018.

The assessors sighted the Healthscope (HS) Attestation Statement that applies to all HS hospitals including TVC was signed by James Gordon, Chair of WHS & Clinical Quality Committee and Steven Rubic, CEO, in September 2021.

The Victoria Clinic (TVC) is a 52 bed sub-acute mental health inpatient treatment facility with three beds closed at the time of this assessment. Plans are well advanced for it to move to a new 67 bed six story building adjacent to the clinic in September 2022. The current facility will be refurbished so that an enhanced multi-building psychiatric hospital will be open in February-March 2023 with 115 beds. The clinic currently has a multidisciplinary team of 69 clinicians and support with 19 active VMOs. Since the previous ACHS assessment, the staff establishment has been enhanced with the appointment of three sessional Consumer Consultants and a part-time Indigenous Liaison Officer. Since the onset of the COVID pandemic TVC has continued to function, despite reduced occupancy, with the adoption of a range of sanctioned precautions to ensure the safety of both patients and staff. The Day Program was offered via Zoom but has since returned to face-to-face functioning and the occupancy is progressively returning to optimal levels with the current length of stay of patients ranging from 2 to 4 weeks. The rate of staff Sick Leave increased significantly as a result of COVID and this impacted on staff morale with the organisation's Employee Assistance Program (EAP) counselling service, registering increased patronage. Morale has since returned to a high level, and this was evident to the assessors throughout their time at TVC.

TVC is one of 43 hospitals governed by the Healthscope (HS) Board with the Head Office based in Melbourne. The HS corporate structure is comprehensive and is being separately accredited by ACHS. It is well resourced with a transparent governance structure comprising a number of (health) subject matter experts and peak committees that ensure all hospitals in the organisation are provided with ongoing support and encouraged to achieve optimal functioning through quarterly oversight of relevant KPIs that are trended and benchmarked. Approximately 18 months ago a new position Mental Health Manager was established. This position reports to the chief Operating Officer who in turn reports to the HS CEO. TVC General Manager (GM), along with the GMs of the other five standalone mental health facilities, reports to the Mental Health (MH) Manager.

This NSQHSS2 OWA assessment was conducted by two experienced assessors both of whom have assessed other HS hospitals in recent years. The methodology employed included a site inspection, verification interviews with key senior clinicians and managers as well as with two Consumer Consultants and the Indigenous Liaison Officer and review of organisational policies, surveys, audits, quality projects and other documents accessible on the TVC intranet. During visits to the two wards (South and North), where TVC patients resided, the assessors employed a patient journey approach that involved consulting with both staff and patients.

This was a very successful assessment for TVC. All Actions Not Applicable were endorsed with all other action items being rated as Met. A recommendation will be made for continued accreditation. All the requirements of the relevant ASQHC Advisories have been met. The assessors were impressed with the values-based culture permeating the hospital environment and reflected in the compassion and respect shown to and amongst patients, staff and visitors. Consistent commitment to the accreditation process was demonstrated across all departments as was the embedded compliance to all of the requirements of the NSQHSS2.

Below is a summary of the organisation's performance against the requirements of each standard:

Standard 1

The governing body of TVC is the Healthscope (HS) Board which delegates its operational governance to the HS corporate body and in particular to the Mental Health Manager. The lean TVC organisational and committee structures mirror closely those of the corporate body. This arrangement facilitates a transparent, accountable and supportive governance structure involving the monthly and quarterly reporting of a cohort of activity and performance KPIs and the ongoing support of senior clinicians that include the HS Chief Medical Officer. TVC has in place comprehensive HS frameworks aligned to its size in policy development and management, quality improvement, risk and incident management, credentialing and safety management that are tweaked to meet the specific requirements of a private psychiatric hospital that admits only voluntary patients. The local Aboriginal and Torres Strait Islander framework flows from the HS Reconciliation Plan and has been endorsed by the local Aboriginal community for the hospital's genuine commitment epitomised by the recruitment of an Indigenous Liaison Officer. The spectrum of Human Resources services from recruitment, orientation, performance management, mandatory training and skills competency development are informed by HS policies, procedures and monitoring and ensure that the multidisciplinary clinical teams and the credentialed VMOs are appropriately experienced and skilled to ensure evidence-based treatments and care provision.

Standard 2

HS corporate has a well-established and evaluated consumer partnership framework comprised of paid Consumer Consultants and an overarching Consumer Partnerships Best Practice Committee plus a series of policies promoting consumer participation. At TVC, the last 12-18 months has seen a significant enhancement in its local framework. This has included the recruitment of three Consumer Consultants as peer workers and members of key hospital committees (e.g. Leadership, Quality, Infection Control) and increased patient feedback channels that have resulted in consumer-initiated changes to the TVC Day Program, patient information in publications and on the hospital website and changes in the design and fit out of the new extension to the hospital planned for opening in March 2023. Most importantly the HS and TVC forms and protocols for the admission, care planning, review and discharge of patients are such that they cannot be properly completed unless the patient is genuinely involved in the decision making. Documentation audits ensure near 100% compliance with this requirement.

Standard 3

TVC has an impressive ICP framework epitomised by a dedicated Infection Prevention Coordinator (ICP), an Infection Control (IC) Committee with membership that includes an external expert (The HICMR Consultant) and a Consumer Consultant. There is safe and appropriate use of antibiotics as part of the Antimicrobial Stewardship (AMS) program that includes a contracted Pharmacist. Both IC and AMS risk assessments and associated audits are conducted, and appropriate training is provided to ensure that the hospital is optimally safe for both patients and staff. Relevant IC and AMS KPIs are reported and benchmarked. All staff are appropriately immunised and the organisation's COVID Safe Plan has successfully minimised the impact of the COVID pandemics on the hospital allowing it to always remain open to accepting admissions.

Standard 4

The governance of medication management is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents. Staff are provided with medication management training that is commensurate with their roles. Incidents are recorded in the organisation's risk management system, RiskMan, which are reported to the quarterly meetings of the Pharmacy and Quality Committees, and to quarterly meetings of the Medical Advisory Committee. The regular audits that are reported in the MARS audit and reporting tool, confirm that there is a high degree of compliance with the completion of the best practice medication history (BPMH) for all patients. The attendance of the assessors at bedside handovers demonstrated that the close relationship that exists between TVC clinical staff and patients ensures that patients fully understand the medications prescribed and are part of the decision-making process. The contracted HPS Pharmacy service to TVC is a resource that is available to assist clinical staff in the education required for the medication safety program, for S4 and S8 high risk medications, in the storage and availability of medications, and to assist staff and patients during the preparation of medication lists at discharge.

Standard 5

The multidisciplinary teams that support TVC are supported by policies and procedures for effective comprehensive care planning and treatment. Processes in place encourage the partnering of patients in decision-making and in the development of comprehensive care plans. Regular audits are conducted of the completion of risk assessments and of clinical documentation that include patient-centred goal setting and the assessment and recording of any risks. Optimal compliance with policy is consistently achieved. Falls prevention and management systems are in place and subject to ongoing evaluation. A nutritional assessment is undertaken during the admission process and feedback provided in patient surveys have resulted in improvement to TVC menus selection process. Cognitive impairment and delirium screening and the monitoring of a patient's cognition occurs frequently, and clinical observations are reported in the patient's medical record. Compliance with all patient observations was reviewed by the assessors and determined to be of a high standard. Advance Care Directives are not undertaken by TVC but there are related policies including the process for staff to follow should a patient be admitted who has an Advance Care Directive. The standard of care provided by TVC is commendable. The close relationship and rapport that exists between clinicians and patients was evident during the clinical handovers attended by the assessors and during observations of the provision of care in TVC.

Standard 6
Policies and procedures are in place to support that appropriate identifiers are used during the admission process, procedure matching, transfer of care, handover and during the discharge process.

Observations by the Assessing Team confirmed that three identifiers are used to identify a patient.

Compliance in the use of the identifiers is audited, and where there have been concerns, further education has occurred, and more regular audits have resulted in greater compliance. The Assessors followed a patient journey which included hand-over, risk assessment and the time-out process. This demonstrated that clinicians were 100% compliant at every part of the process. Where incidents occur, these are reported in the RiskMan tool, and are reported to the monthly Quality Committee.

Standard 7
Not applicable

Standard 8
The nature of the care provided by TVC means that clinical staff are always vigilant to any possible deterioration in the condition of a patient. Monitoring of patient observations, which are documented in the medical record, are constantly reported. Policies and procedures are in place to ensure that staff are trained in clinical deterioration, and that patients are aware of the process to follow should they, or another patient be seen to deteriorate. Code Blue drills are scheduled to guarantee that staff are aware of the processes to be followed, and the equipment to be available during times of a patient deterioration occurring. A recent mock example of this resulted in further training provided to staff, and future exercises scheduled to ensure that the lessons learned had been adhered to, and in the new environment when staff move to the new TVC buildings. The small team of dedicated TVC clinicians are well trained, respected and have an excellent rapport with their patients.

Summary of Results

The Victoria Clinic achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

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

Sites for Assessment
The Victoria Clinic

Site	HSFID	Address	Visited
The Victoria Clinic	101121	324 Malvern Road PRAHRAN VIC 3181	Yes

Standard 1 - Clinical Governance

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

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
The governing body of TVC is the HS Board and their responsibilities are delegated in a very transparent, accountable and supportive way to the General Manager (GM) via the HS Director of Corporate Services and the Mental Health Manager. There are peak committees and senior health professionals at the corporate governance level that directly influence the performance of the TVC across a range of activity areas. HS Values and Mission facilitate the development of a culture of optimal safety and quality improvement, and this is reflected in a cohort of safety and quality KPIs that the GM is required to report on quarterly to the HS Corporate Body. The organisational structure and efficient committee structure clearly promotes safety and quality improvement. The peak TVC committees are the Medical Advisory Committee (MAC) and the Leadership Committee to which 4 other committees report namely the Quality Committee, the Work Health and Safety Committee, the Infection Control Committee and Pharmacy Committee. This TVC committee structure mirrors a similar committee structure at corporate level, and both have similar standing agenda. Monthly or quarterly safety and quality KPI reports are reviewed at TVC committee level and then forwarded to the respective corporate counterpart where they are benchmarked with comparable facilities. Where TVC falls below the set benchmark the corporate committee provides an action plan to address the deficit. HS has a Consumer Partnership framework established at corporate level that informs the local framework at TVC. There is a HS National Consumer Advisory Council, a HS Consumer Consultant Vision Statement and a HC policy on Consumer Participation and Partnership. Since the appointment of the HS (Victorian) MH Manager, a 5-year MH Strategic Plan has been developed, the implementation of which is at the local level. TVC has a comprehensive Clinical Governance Plan (Safety & Quality Plan) 2021-2025. These TVC planning documents are informed by the over-riding One Healthscope 2025 Strategy and endorsed by the HS Board via the HS Clinical Quality Committee. The GM formally reports on the implementation of the Clinical Governance Plan annually under two headings: Achievements and Planned Improvements.

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
There are Human Resources processes in place that ensure that the skills of the multidisciplinary clinical and support staff establishment are aligned to the needs of the targeted patient group admitted to TVC. Plans have been developed to enhance the staff establishment so that it is appropriately skilled and resourced to meet the needs of the increased bed state of 115 in March 2023. Clinical incidents are reported and managed locally in the HS RiskMan system. A safety and quality KPI report, that includes incidents, is forwarded to HS Corporate each month where it is benchmarked.

Rating	Applicable HSF IDs
Met	All

ACTION 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Comments
The HS Reconciliation Plan (RAP) "contains strategies to close the gap between health outcomes for Aboriginal and Torres Strait Islanders and other Australians". It applies to TVC and contains strategies that meet the requirements of this and other relevant actions in this standard. TVC has an Aboriginal and Torres Strait Islander Engagement Plan July 2021-July 2025 that is aligned to the RAP. The Leadership Committee oversees the implementation of this plan as evidenced by a review of committee minutes. One outcome achieved thus far is the recruitment of a local elder as the TVC Indigenous Liaison Officer, who attends the clinic whenever a patient who identifies as an Aboriginal or Torres Strat Islander person is admitted of which there have been six in the previous 18 months. Other outcomes include the commissioning and purchase of Aboriginal artwork that has been strategically placed throughout the facility, an acknowledgement of Country at the beginning of all meetings, placement of the Aboriginal flag at the reception counter and hospital-wide celebration of NAIDOC Week and Sorry Day. The hospital has actively consulted with the Aboriginal Liaison Officer and her community in the development of these initiatives. She advised the assessors that other initiatives are being planned.

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
The hospital's Clinical Governance Framework is comprehensive and includes the establishment of partnerships with key stakeholders, regular reporting of clinical KPIs and Hospital Acquired Complications, incident data and clinical audits. It also includes the development of sustainable systems to manager risks, facilitate quality improvement and provide evidence-based practice through having an appropriately resourced and skilled staff establishment and ensuring consumer participation at all phases from pre-admission to discharge. The assessors were provided with compelling evidence of all these structures being operational and achieving their stated objectives.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.04	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
The strategies implemented to ensure that the admission of Aboriginal and Torres Strait Islander patients is optimally safe and of optimal quality include the appointment of the Indigenous Liaison Officer, who supports all indigenous patients throughout their patient journey, and the placement of welcoming symbols and signs throughout the facility. These are under continual review based on feedback received by the Indigenous Liaison Officer.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
In implementing the strategic plan and achieving the documented strategic goals, the TVC leadership team led by the GM is obliged to always ensure the safety and quality of healthcare provided to patients. These are fundamental HS principles and the required monthly and quarterly reporting of safety and quality KPIs ensures this values-embedded practice is maintained. An example provided was the removal of potential ligature points by the removal of bathroom doors in the innovative design of the new six storey extension to the facility.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
Each clinical discipline has a Discipline Head who ensures that all staff under their direction performs their delegated safety and quality roles that are documented in their respective Position Descriptions PDs. This is achieved through a range of administrative mechanisms including annual performance appraisals at which time the PD is reviewed and amended as required, participation in clinical reviews and staff meetings and participation in formal supervision (for registrars and allied health clinicians). A central registrar is maintained of each staff member's vaccination status (mandatory) and staff are not permitted to work until this requirement is met. Currently three staff have left because of this mandate and two staff are awaiting a review of their exemption application. VMOs participate in Peer Review sessions to monitor their performance plus their performance is formally reviewed prior to being re-credentialed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Comments	
TVC is progressively moving to the situation where it will have only HS corporate policies and a minimal number of local policies. There are currently only ten of the latter that pertain to TVC-specific patient access, admission exclusion criteria, nurse-initiated medication, administration, and emergency procedures. All HS and TVC policies are risk rated High, Medium or Low with their review dates respectively 1, 2 or 3 years. The Quality Manager is the local manager of policies and sends new and updated policies to each staff member's email address accompanied by a message outlining the relevance of the policy to their clinical practice. Highly relevant policies are also discussed at respective staff meetings. When relevant the Staff Educator or Clinical Nurse Educator will conduct an in-service to explain an important new policy. Non-compliance with policy is indicated when an incident review occurs and this is identified as a contributing factor. The assessors were advised that this is a rare occasion and when a particular staff member is identified as being non-compliant with respect to Medication Policy, for example, there is a set protocol for their manager to follow that involves the staff member completing a Medication Incident Reflection Tool with this being the basis of a discussion. The review of all HS policies is undertaken by the corporate National MH Best Practice Committee and the National Document Control Committee. Policy review always involves consultation with key stakeholders that includes consumer representatives.	
Suggestion(s) for Improvement	
Investigate a more pre-emptive approach to promote staff cognizance of high-risk policies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Comments	
TVC has a comprehensive Quality Improvement (QI) Framework that includes the dedicated Quality Manager position, a Quality Plan, a Quality Project Register (currently registering 10 projects) and the new eQUAMS electronic quality management system that accommodates all data and information pertaining to the QI cycle using a template. This framework is the result of a review and enhancement of the previous framework. The assessors consider that eQUAMS is a major innovation that promotes and encourages all projects to follow and complete the QI cycle. Action Plans are routinely initiated in response to identified deficits from corporate benchmarking, audits and incidents. All quality projects are reviewed and endorsed by the Quality Committee with a membership that includes a Consumer Consultant. The organisation has a very comprehensive audit schedule that is aligned to the NSQHSS2. Other major QI projects include stakeholder feedback surveys from patients on their discharge (the YES program) and annual satisfaction surveys of staff and VMOs Results of audits, surveys and other QI projects are circulated on the facility notice boards and on the TVC website.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.09	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	
Monthly reports on a cohort of safety and quality KPIs are prepared by the Quality Manager and reviewed and analysed by the Quality Committee. They are then provided to the relevant TVC and HS committees, to staff via hospital newsletters and notice boards and to the general community through the TVC website. These reports and their circulation are under continual review.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Comments
There is a comprehensive risk management system that includes the Quality Manager as its operational manager, the Quality Committee providing local oversight, an electronic Risk Register (RR) that is a "living instrument" of all risks identified and managed. There are set rules that inform its operation including setting Moderate or Low as the acceptable Residual Risk rating. Risks are identified through a range of sources that include the PERT (Ligature) audits, Work Health and Safety (WHS) audits, incidents, and annual staff brainstorming at planning days. The status of the RR is reviewed at meetings of the Quality Committee as well as at the corporate level where it is benchmarked. Action plans are routinely developed and activated in response to risks if immediate action cannot be taken at the coalface. Risk management is included in both the organisation's orientation and mandatory training programs. The assessors consider the TVC risk management system to be near best practice as evidenced by the constant and effective activity of the RR.

Rating	Applicable HSF IDs
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
Incidents are a standing agenda item at all staff meetings and monthly RiskMan Reports are reviewed by the Quality Committee and then circulated to the Leadership Committee and the Medical Advisory Committee (MAC). There are few incidents reported with the main ones being infrequent patient falls, medication errors, patient behaviours (for example patient self-harm wounds). The low rate of reported incidents provides justification for the hospital identifying itself as optimally safe for patients and staff alike.

ACTION 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
HC has an Open Disclosure (OD) Policy that is adopted by TVC. OD is included in the Orientation Program and all RiskMan entries require a tick that OD has been used in response to the reported incident. The incident management system is reviewed and amended on a continual basis in response to each reported incident at TVC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
There are a number of mechanisms operational that prompt stakeholder feedback, namely: 1. From patients via the YES questionnaires that are emailed to all patients immediately they are discharged (20% return rate is currently achieved) and the National Patient Experience Register. 2. From staff via the annual staff satisfaction survey	

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
3. From VMOs via their annual feedback survey 3. From Consumer Consultants feedback reports (provided to them by patients and carers). Patients are encouraged to provide feedback in the Patient Information brochures and staff through the GM Newsletter. HS Corporate monitors the response rate and benchmarks them with comparable facilities. Action plans are activated when the result is below benchmark.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	
There is a HS Complaints Policy that specifies timelines to manage and respond to formal complaints. TVC receives very few formal complaints with most complaints being able to be satisfactorily addressed at the ward level. Main themes of complaints are being allocated a shared room rather than a single and delays in accessing individual counselling. All complaints are recorded, in RiskMan and reviewed by the Quality Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care
Comments
The patient cohort at TVC has traditionally been very homogeneous. There are very few patients who seek admission who are from culturally diverse backgrounds with limited English. This is probably a reflection of the private status of the hospital with patients in the main required to have private health insurance to be admitted. This has not stopped the hospital from providing hospital and patient information brochures and providing access to interpreters when required. Of note is the cultural diversity of the staff establishment. The major factor contributing to the patient mix of TVC is being a patient of one of the 19 active VMOs with admitting rights to the hospital. Accordingly, patients come from anywhere in Victoria but the majority live within a radius of 20 kms from the clinic. In recent years the main diversity issue has been gender with some of the VMOs admitting patients who are gender fluid, transgender and gay. The Consumer Consultants have provided a number of in-services on LGBTIQI issues and how to provide appropriate care to these individuals. Currently the hospital is preparing to be audited against the Rainbow Tick standards. As documented earlier in this report a small number of Aboriginal people have been admitted in the recent past and the hospital has and will continue to provide ongoing support and culturally appropriate care to these patients.

Rating	Applicable HSF IDs
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
TVC has a dedicated Health Information Manager (HIM) who, in addition to being the site Privacy Officer, is the Medical Records Manager. In the latter role he completes coding and statutory reporting and manages access to records storage requirements, auditing, privacy and education. He oversees the TVC medical record which is paper-based and kept in the staff base of the respective wards. Hard copies are made of all digital test forms and letters and inserted in the medical record.

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
They are accessible to staff at handover and accompany the patients when they are escorted to the TMS rooms and ECT at The Melbourne Clinic (TMC). HS is currently trialling a digital medical record (EMR) at several of its facilities and once endorsed the new format will be rolled out to all 43 HS hospitals. There are HS Documentation and Privacy Policies, an overview of which is included in the Orientation Program and at ward induction. A comprehensive medical record documentation audit covering contents is conducted every month and action plans are initiated to address non-compliant areas. Successive audits demonstrate a high level of compliance with policy. The major area of non-compliance is lack of a patient signature. There is an ongoing audit of the format of the medical record. The HIM collects medical file data that is required to be reported to Vic Health and the Private Psychiatry Group. This data includes that for Case Mix, Admission Type, HoNOS scores and Length of Stay. When not being used, medical records are securely locked in a cabinet located in the respective staff base.

Rating	Applicable HSF IDs
Met	All

ACTION 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Comments
The MyHealth Record system was implemented during 2015/16 at all HS hospitals. The current status at TVC is that, with patient consent, event summaries and Nursing Discharge Summaries are automatically uploaded to the My Health Record (MyHR). Patients are provided with a MyHR Brochure on admission explaining the MyHR and how to register your name in it. Currently a little over 50% of patients have consented for this to happen. HS is implementing an action plan to meet the 3 separate requirements of this Action in the stated timeframe. At TVC full implementation will need to await the introduction of the electronic medical record (EMR) that is being progressively established across the 43 hospitals network. Currently HS uses the National Glossary (national patient and provider identifiers and standard terminology) for MyHR. The organisation has complied with all of the requirements of this action and AS18/11.

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
There is a HS My Health Record Policy that only allows the GM at TVC to access the MyHR subject to obtaining patient written consent. As documented in action 1.17, only event and discharge summaries are uploaded in an automated way to MyHR as "content contributors". HS authorised IT personnel have access to MyHR to monitor the quality (accuracy and completeness) of the upload. This effectively is an audit with the results forwarded to the GM for action as required. The requirements of this action and AS18/11 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
There is no dedicated Human Resources Manager or similar in the TVC staff establishment. The Executive Assistant (EA) to the GM, however, has responsibilities to coordinate and document the recruitment and orientation of new staff using the Oracle system. There is a HS protocol/pathway for recruiting staff and the EA monitors it for each new staff using a checklist. The operational responsibility for each recruitment is the relevant Team leader or Nurse Manager. Once a person has been selected, documentation about the recruitment is forwarded to the GM for endorsement.	

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Once onboard, the new staff member participates in the orientation program with most educational units accessible online. These are complemented by the Educator or a delegate providing in person training in Basic Life Support (BLS), AT, Quality Improvement and Risk Management. The staff member then works in their ward or department as a supernumerary for one day before being fully integrated into the staff team. The EA maintains a data base of each staff member's training record and staff are assertively prompted by their respective manager if they have not completed any of the designated training sessions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Comments	
There is a HS Mandatory Policy that requires all staff to complete annual mandatory and one-off mandatory training requirements. Wave 2 is the specific component for mental health clinicians. The EA maintains a database of completed staff participation in mandatory training programs. Respective managers monitor compliance of all their staff and prompt those who still have to comply with all the requirements. There is a HS KPI about the % of staff who have completed their mandatory training and this is reviewed at local level and benchmarked at corporate level. Competency training is mandated for nurses working in the ECT and TMS areas. This is arranged by the TVC Educator. As the need arises the TVC Educator or Clinical Nurse Educator will organise specific competency training programs as required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Comments	
All TVC staff are required to complete online Cultural Competency training and their participation is monitored at both local and corporate levels. The Indigenous Liaison Officer routinely provides in-services about local Aboriginal culture and how to provider culturally appropriate care to patients who identify as Aboriginal or Torres Strait Islander. There is continual review of all educational sessions with tweaking of content and presentation based on feedback received.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Comments	
There is a HS performance appraisal framework that is implemented at TVC annually. Completion of appraisals is a KPI that is tracked on the HS eLearning tool. At the time of assessment, the TVC rate was 94%. Staff training needs in the areas of safety and quality are identified through this program and contribute to the inhouse education program organised by the TVC Educator.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Comments
There is a standard HS Credentialing Policy and associated procedure. Currently 19 VMO are formally credentialed to admit patients to TVC with an endorsed scope of practice that is aligned to the needs of the patient cohort that meet the hospital's admission criteria. All VMOs are required to be recredentialed every three years with newly credentialed VMOs one year after their initial credentialing. It is at this time that a VMO's scope of practice is modified or re-endorsed. The MAC, Medical Peer Review and multidisciplinary are mechanisms where a VMO can be monitored with respect to working within their prescribed scope of practice. A new ECT Clinic is being established in the new TVC building with the first patients being accepted in September 2022. Management has so far received 4 EOIs from currently active VMOs to undertake ECT training. TVC already has a small cohort of trained ECT nurses who have escorted patients to TMC to receive their ECT treatment. In accordance with HS policy, EOI are sought whenever a new procedure or technology is to be introduced with specialist training provided to those accepted. With respect to nurses and allied health clinicians, the Senior Nurse and Allied Health manager monitor respectively their staff annual APHRA registration. Scope of practice is documented in all Position Descriptions and these can be amended annually at the time of the scheduled Performance Appraisal. The requirements of A18/12 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
At TVC the EA manages the implementation of the HS Credentialing Policy in consultation with the Medical Director. She maintains a database of all VMO credentialing and recredentialing data and information. An annual audit of medical indemnity insurance is conducted by the EA. VMOs who do not have current insurance are assertively followed up and are not permitted to practice in TVC until this issue is addressed. The HS Chief Medical Officer is currently reviewing the HS By-laws in consultation with key stakeholders. The Credentialling Policy is reviewed at corporate HS level every three years or earlier if required and it is at this time that the effectiveness of the credentialing process is evaluated with changes made when problematic issues are identified. The requirements of A18/12 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Comments
TVC has a comprehensive WHS framework in operation that includes a range of HS policies, a WHS Committee that meets bimonthly, the use of RiskMan to register and manage hazards identified through the monthly environmental audits and a trained WHS Officer. The incumbent of the latter works across two other neighbouring HS hospitals. She has been in that position for seven months and in that time, she observed a significant under-reporting of environmental hazards. In response she and members of the WHS Committee conducted a Spot the Hazard competition as part of Safety Week celebrations. This competition enabled 8 new hazards to be identified and registered in RiskMan. It also facilitated a renewal of the monthly environmental site Inspection process. The invigorated process now involves the monthly inspection utilising a new checklist that focuses on a different theme each month. Themes include Slips, Trips and Falls", "Emergency Procedures" and "General Health and Safety". Additionally, both wards and other hospital departments have a senior staff member who holds the WHS portfolio (the WHS Champions), is a member of the WHS Committee and conduct the aforementioned WHS environmental audits. The WHO Champions, aided by the WHS officer, also support and educate staff about safety issues to facilitate an optimally safe work environment. The WHS committee reviews all environmental site inspections and a summary report of recommendations is provided to both the Quality and Leadership Committees.

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Suggestion(s) for Improvement	
Enhance the current environmental site inspection process by ensuring that an independent WHS portfolio holder conducts the inspection of a ward/department. This would necessitate the establishment of roster for the WHS portfolio holders.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
The Position Descriptions of the NUMs, Allied Health Manager, GM and other departmental managers stipulate that they are responsible for ensuring that staff under their direction work according to their respective Position Descriptions and in compliance to HS and TVC policies. Apart from the annual staff appraisal process, these managers also provide informal supervision, support and guidance to their staff either individually or in staff meetings. Clinical Review meetings also provide a regular forum for staff supervision. Allied Health clinicians and psychiatric registrars are provided with access to individual clinical supervision whilst VMOs participate in Peer Review. There are established documented pathways for afterhours clinicians to access clinical advice. There is always a senior nurse on duty on the evening and overnight shifts and the VMOs have an on-call roster. Staff satisfaction surveys have not identified poor supervision as an issue, in fact the vast majority of staff report that they feel well supported by the organisation. There is an EAP service accessible to all staff outside business hours and this service registered significantly increased patronage during the pandemic lockdowns.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Comments
At corporate HS level, the Mental Health Manager has coordinated the development of a Mental Health Strategy for HS. The progressive implementation of this strategy has involved a major review of all Mental Health related policies and procedures ensuring that they are based on current best practice and evidence and aligned to current government policy and legislation as well as the NSQHSS2 and the ACSQHC Standards and Advisories. For medical staff, best practice evidence is sourced through a number of electronic apps including MIMs and Best Practice Guidelines. The HS Chief Medical Officer and corporate clinical committees ensure through a range of feedback channels that every HS facility is operating according to best practice with a contemporary evidence base. HS and TVC participate in the ACHS Clinical Indicator program that provides feedback about how the hospital is performing against a benchmark across a range of clinical indicators. Action plans are initiated in response to every instance of the hospital falling below benchmark. Evidence was provided of the hospital performing consistently at benchmark or above. The requirements of A18.12 (1.27b) have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
Comments
All serious clinical incidents are required to be registered in RiskMan where they are reviewed both at TVC and HS committee levels. In the past two years only one serious incident was reported and that was of a patient suicide in his ensuite bathroom. In response to this incident and as a prevention initiative all bathroom doors have been removed and will not be installed in the new six storey extension opening in September 2022. Every six months HS Corporate distributes to the GM and Quality Manager and their equivalents in the 42 HS hospitals, a paper entitled "Shared Learnings" that summarises the organisation's lessons learnt from all serious incidents registered in the preceding six months across the organisation. Most of these do not apply to TVC but they do provide stimulus for reviewing all issues impacting on the safety of patients and staff alike. The fortnightly multidisciplinary clinical reviews and daily nursing bedside handovers, MAC meetings and Medical Peer reviews are all accountable mechanisms that TVC has operational to monitor variation in clinical practice and provide clinicians with feedback about their clinical practice. The monthly report on safety and quality KPIs, reviewed by the MAC, Quality Committee and Leadership Committee and then by their equivalents at HS Corporate level, provide a measure of the care provided at TVC relative to their benchmark partners. Variations in clinical practice and negative outcomes are detected and analysed at a range of levels and remedial action is undertaken to ensure that the care provided at TVC is evidence-based and optimally safe. The requirements of A18/12 (1.28a) have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
Optimal safety and quality of care are facilitated by the work stemming from the WHS framework that has been significantly enhanced with the arrival of the new part-time WHS Officer. A number of WHS KPIs are reported quarterly to HS corporate where they are benchmarked. TVC has recorded exceptional results in the past 2 quarters. One high scoring indicator is the number of interactions between the WHS Officer and the GM and this reflects the commitment of senior management to WHS at the hospital. Issues are tabled at meetings of the WHS Committee and all identified hazards are recorded in RiskMan. BGIS is the external provider of maintenance and repair services on a 24/7 basis with response time aligned to risk status. The assessors noted that there had been no Lost Down Time to Injury (LDTI) at TVC for well over three years. A number of quality improvement projects have been undertaken by the WHS Committee including the revised environmental audit process and a review of the SDMS Log with some being updated and others erased. BGIS is owned by the same owner of HS and is effectively the "Internal Contractor" for TVC. A BGIS Liaison Officer has been appointed to cover TVC and arranges for the induction of all new contractors working on site. He also holds regular meetings with the GM to identify systems and services that require evaluation. There is an annual Prevention Maintenance Schedule.

Rating	Applicable HSF IDs
Met	All

ACTION 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Comments
TVC has established admission and exclusion criteria that result in the non-admission of high-risk patients. All patients admitted have voluntary status and are assessed at pre-admission as low risk. There is established criteria for transferring patients to an acute mental health facility at The Alfred Hospital. This occurs on average every six weeks. All patients are risk rated on a daily basis with respect to both their physical and mental health. A patient's risk rating needs to be low for unescorted leave to be approved. There is a HS Leave Policy that informs the local practice.

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
The shared bedrooms in the current TVC building are quiet areas according to patients interviewed by the assessors. The new extension has been designed in consultation with consumer and carer representatives. Quiet areas have been allocated, an example being a lounge room without a television. There are also individual consulting rooms that can be used for respite and the single bedrooms will also provide a quiet area for patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
Signage has not been identified as an issue in any of the feedback mechanisms utilised by patients and carers. The Consumer Consultants report that they will be conducting an annual signage audit as one of their planned activities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
Current TVC policy during COVID is to not allow visitors into the facility. Normal visiting between 4 and 6pm may return once the pandemic is over. There is also TVC policy not to accept admissions outside of business hours when essential admission staff are not on duty. The GM advised the assessors that some flexibility is permitted to suit the circumstances of some patients if this is endorsed by their admitting psychiatrists.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
The Indigenous Liaison Officer advised that the feedback she has received from former Aboriginal patients and her community is that the initiatives implemented by the hospital thus far provided a very welcoming entry and environment for patients who identified as Aboriginal or Torres Strait Islander. The initiatives included Aboriginal artwork being placed throughout the facility, having an Aboriginal flag at the reception desk and appointing her to a permanent staff position.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers
Comments
At the HS corporate level there is a robust Consumer Partnership Framework that informs and supports similar frameworks at its network hospitals. Core components of the framework are the following policies: "Consumers-Partners With", " Consumer Consultants" and "Consumer Approved Publications". Then there is the Consumer Partnership Best Practice Committee that has a representative from TVC as a member and which is aligned with the National Consumer Advisory Council. There are also Consumer Consultants having membership of peak HS Committees that include the Quality and Best Practice Committee and the National Accreditation Steering Committee. Under the umbrella of this substantial corporate framework, in the past 18 months TVC has significantly enhanced its own framework to actively promote consumer participation across all levels of the organisation. There are now three paid Consumer Consultants (making up 0.7 FTE position) and one Indigenous Liaison Officer, most of whom are ex-patients of TVC. They not only provide a consumer perspective on each of the hospital's key committees, including the peak Leadership Committee, but also provide peer support to inpatients and hold portfolio responsibilities covering quality improvement, infection control and WHS. This comprehensive framework is operationally supported by the Quality Manager and is being progressively evaluated. The recruitment of the Consumer Consultants is underpinned by risk management principles and follows the same process applied to the recruitment of all TVC staff. Additionally, the process benefits from lessons learnt from HS corporate experience. The training requirements and orientation program for Consumer Consultants adopts those of the corporate program with a local flavour. TVC have been briefed in in-services about the role of the Consumer Consultants and ways they can facilitate consumer participation at all steps of the patient journey.

Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers
Comments
TVC has a comprehensive audit schedule that measures compliance with HS consumer participation policies. These audits include the comprehensive documentation audit that audits the contents of the medical record. There are also various consumer feedback mechanisms that provide a measure of consumer participation in the assessment, care planning and review and discharge processes. These mechanisms include the Patient Experience "Yes" Survey that is benchmarked across the HS Mental Health cluster and the Net promotor Score that measures the willingness of patients to recommend TVC to potential patients. Patient completion of Yes surveys is 20% and comparable to other sites. To improve this response the Consumer Consultants have been asked to promote completion of these surveys among the current patients to whom they provide support. It is anticipated that the response rate of the next survey will be above the benchmark. TVC reports on four Consumer participation KPIs each quarter where they are benchmarked within the HS Mental Health cluster of six hospitals. The KPIs concern Net promotor Score, Bedside Handover, Patient Care Board and Patient Rounding. Currently the overall rating for TVC is 61%.

Rating	Applicable HSF IDs
Met	All

ACTION 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers
Comments
TVC routinely providers all patients with an information pack that includes a brochure on patient rights. This document is based on the Australian Charter of Healthcare Rights. The TVC documentation audit includes checking that the rights brochure has been given to patients and its contents explained. Near optimal compliance with policy is consistently achieved. Currently TVC does not permit visitors because of COVID restrictions but there is an information pamphlet explaining to patients how they can maintain contact with their family and friends whilst an inpatient.

Rating	Applicable HSF IDs
Met	All

ACTION 2.04	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	
On admission each patient is required to sign several consent forms that include agreement to treatment, acknowledgement of their financial obligation and consent to having their photo taken and included in the medical record. If a patient is prescribed TMS or ECT during their stay or prior to admission they are required to sign consent forms specific to that treatment. These forms are kept in the medical record and audited. Auditing consistently reports a compliance rate of 100% for patient signatures, with an outlier being the patient doesn't always date their signature. Steps are taken to correct this finding.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.05	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
Apart from a few exceptions, TVC only admits patients who have been referred by an admitting psychiatrist who is familiar with the patient. Since the previous ACHS assessment the hospital has only admitted people who have been assessed as having the capacity to make independent decisions. Should a patient's mental state become acutely disturbed during their stay and they lack this capacity they are scheduled by their psychiatrist and transferred to an acute psychiatric ward at The Alfred Hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Comments
The HS/TVC policy on Partnering with Consumers requires patients to be actively involved in all aspects of their care at every stage of their inpatient journey. The structured format of the TVC forms required to be completed at the pre-admission, admission, care planning/review and discharge planning stages requires the patient, with prompting, to be actively involved in supplying personal information to the attending clinician (registered nurse, registrar, psychiatrist or allied health) and then signing the forms to indicate their agreement with the contents. Throughout the patient's time at TVC informal auditing is conducted by staff on the following shift or next day to clarify the contents if they are unable to read the signature or it is missing. Additionally, formal monthly auditing of the medical record facilitates optimal accurate completion of all forms as the audit results are promptly provided to the awards and relevant departments. The Patient Care Boards are placed strategically near each patient's bed. The boards include a section where patients can write down any concern or issue, they wish to be discussed at the next bedside handover. There is a policy dictating patient active involvement in bedside handover and auditing indicates a high level of compliance with policy. Feedback provided to the assessors from the Consumer Consultants was consistent with survey results that indicated that patients were very positive about their patient experience most notably in being encouraged to contribute to decision making about their care.

Rating	Applicable HSF IDs
Met	All

ACTION 2.07
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care
Comments
Patient participation is a standing agenda item of the organisation's orientation and ward induction programs. All staff are required to be cognizant of the policies impacting on their work practice and the NUMs interviewed advised the assessors that patient partnership was regularly discussed at multidisciplinary staff meetings especially when new registrars, graduate nurses and allied health interns have joined the ward staff profile. Both Consumer Consultants and the Indigenous Liaison Officer reported that they had provided staff in-services, from an ex-patient perspective, of how best staff can ensure that patients are actively involved in their care in a positive way. The assessors were advised that these in-services would be repeated at regular intervals. "Yes" survey results confirm that patients in the main consider that they are actively involved in decisions about their care.

ACTION 2.07	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
All clinicians interviewed reported that patient participation was an integral part of the care they provide.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.08	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
Being a private psychiatric facility, the vast majority of patients admitted to TVC have private health insurance. This condition of entry impacts on the spectrum of diversity of the patient profile which does not reflect the cultural diversity of the surrounding suburbs. TVC does not have a designated catchment area, admitting patients from all parts of Melbourne and Victoria. An essential criterion for admission is that the patient has an admitting psychiatrist from amongst the current 19 credentialed psychiatrists. By far the largest and growing diversity group admitted to TVC is the gender diverse group (gender fluid and transgender) who are provided with specialist care by credentialed psychiatrists who have an expertise with this group. Despite the limited diversity of the patient profile all staff are required to complete online training in cultural competency and Aboriginal culture. The hospital's onsite kitchen is resourced to be able to provide meals based on dietary requirements or preferences based on health status, religion and culture. In addition, the hospital provides patient information brochures in the most prevalent languages in Melbourne and there are interpreters rapidly accessible should the need arise. The assessors noted that patient feedback provided minimal complaints about meals and access to information. The Consumer Consultants confirmed the assessors' general impression that patients were satisfied with the communication mechanisms utilised by the hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.09	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
All HS and TVC patient information provided in hard copy and on the TVC website has been reviewed by consumer representatives and this endorsement is provided with a special CAP (Consumer Approved Publication) stamp prominently displayed. This practice is informed by the HS Patient Publications Policy. It is also noted that one of the TVC Consumer Consultants has been allocated the portfolio of reviewing and amending the TVC website so that it is optimally informative to consumers. This project was well on the way at the time of this assessment. It is clearly established practice at HS and TVC that consumers are always involved in the development and review of any patient information irrespective of the medium.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge
Comments
The Position Descriptions of the Consumer Consultants and the Indigenous Liaison Officer include the responsibility to support both clinicians and patients at the critical time of admission, particularly of a new patient, and at any other time when their presence is requested by either party. This could only be realised if these consumer representatives were accepted as permanent staff members with a unique skill set and the assessors were able to verify that this is certainly the case at TVC. The incumbents of these consumer positions report that their role as a peer support to vulnerable patients and as a staff member with lived experience of mental health issues is highly valued by both patients and staff. In many instances the consumer representatives are able to allay the fears and anxiety of many patients. Staff advised the assessors that this intervention on either a one-off or continuous basis throughout the admission allows clinicians to engage more quickly with patients and negotiate the best possible care plan for the patient. As soon as engagement is achieved clinicians are in an improved position to ensure that their initial and ongoing assessment is accurate and that the patient fully understands why and how the treatment prescribed will help them.

ACTION 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge
The assessors are aware the position of Consumer Consultants/Peer Workers or similar in the Mental Health area has been the subject of numerous evaluation and research studies that demonstrate their value as a member of the multidisciplinary treatment teams and a local evaluation study would enrich this field of research.
Suggestion(s) for Improvement
Undertake a formal evaluation of the impact on patient outcomes of having Consumer Consultants as members of the clinical team.

Rating	Applicable HSF IDs
Met	All

ACTION 2.11
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
Comments
Currently the Consumer Consultants are members of four major hospital committees where decisions are made about the functionality of TVC. They are in a position where they can seek clarification about the organisation's activity and performance as reflected in the benchmarked and trended safety and quality KPIs that are reviewed every two months. In September 2022, 67 new beds will be available in the completed multi-storey extension built adjacent to the current facility. In accordance with HS policy, consumer representatives have been actively involved in the design and fit out of the new building. These consumers included both local community residents and ex-patients of TVC.

Rating	Applicable HSF IDs
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	
The Consumer Consultants were involved in a comprehensive orientation program prior to the commencement of duties at TVC. The orientation program was based on the comparable program provided by HS corporate to their Consumer Consultants. This program was the subject of evaluation and refinement and the lessons learnt informed the TVC program. Both Consumer Consultants interviewed reported positively about their orientation that included many components of the regular staff orientation with added sessions specific to their role. Prior to their participation as a member of a TVC committee, each Consultant is provided with a brief of the committee's goals and function and advice on how they can participate. The Quality Manager meets formally with the Consumer Consultants on a monthly basis, and she provides guidance, support and supervision as required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
As a local Aboriginal Elder, the Indigenous Liaison Officer has provided hospital management with specific advice about how to make the environment of the facility less intimidating and more culturally welcoming for potential Aboriginal patients. Outcomes of her consultations have been the placement of Aboriginal artworks throughout the public areas of the hospital, placing an Aboriginal flag at the reception counter at the hospital's entrance and acknowledging Country at the beginning of all hospital committee meetings. She sought feedback from her mob and members of it provided very positive views about these and other changes proposed. The indigenous Liaison Officer advised the assessors that she was happy working with TVC as they were very receptive to her suggestions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
The Quality manager meets formally with the three Consumer Consultants quarterly to elicit their feedback, address any problems encountered and provide education about their role as required. The hospital has plans to formally include a session run by Consumer Consultants in the facility's annual in-house educational program. Already the Consultants and the Indigenous Liaison Officer have conducted staff in-services about their personal experiences as a patient highlighting both the positive and negative aspects. These sessions have been evaluated with staff registered high praise for them. The TVC orientation program now includes a session conducted by a Consumer Consultant.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
TVC has a robust Infection Control and Prevention (ICP) framework that is fully integrated in the organisation's clinical governance systems. The framework includes local IC and Pharmacy Committees, a designated Infection Prevention Coordinator (IPC) position, a contract with HICMR (an external provider of ICP services) with a designated HICMR representative regularly visiting TVC to conduct auditing and education sessions. HICMR has an annual Risk Assessment Audit Schedule for TVC. There are also a plethora of HS and HICMR policies and procedures and a contract with a local Pharmacist to conduct onsite audits and in-services. The HICMR Consultant and the local Pharmacist are members respectively of the TVC IC and Pharmacy Committees. The framework is subject to periodic evaluation particularly at the time of reviewing the contracts with HICMA and the Pharmacy. The HICMR Consultant conducts comprehensive ICP risk assessments of relevant hospital areas that include both South and North Wards, Environmental Services, Food Services, Staff Health, Maintenance, Clinical Waste and Linen and follows these up with a schedule of audits to identify any IC issues. The assessors were advised about the action plans initiated in response to the audit results that include HICMR education sessions. The HICMR audits cover Personal Protective Equipment, Facility Cleaning, Linen management and RMD. Results achieved are consistently above the 90% benchmark for TVC. HICMR ensures that the hospital is up to date with all relevant government policies and legislation and takes responsibility for reviewing and updating all their policies that TVC adopts. There are HS Antimicrobial Stewardship (AMS) policies and procedures that apply to TVC. The HICMR Consultant conducts regular in-services on AMS and the visiting Pharmacist is contracted to conduct a risk assessment, onsite audits and in-services to ensure that the hospital is fully compliant with the HS AMS policies.	

Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
The facility's IC Committee is multidisciplinary, and its membership includes senior clinical managers, the IPC, a medical representative, representatives from wards and departments, a Consumer Consultant and the HICMR Consultant. The Pharmacy Committee is also multidisciplinary and has similar membership to the IC Committee except that the contracted Pharmacist replaces the HICMR representative. The IC Committee has Terms of Reference that clearly describe their responsibilities of monitoring and improving respectively infection prevention and the effectiveness of the surveillance system and workforce training. The Pharmacy Committee Terms of Reference describe their responsibilities of promoting effective antimicrobial stewardship (AMS) that includes having skilled staff to implement the AMS. There is a HICMR- Infection Prevention Management Plan 2022 and the ICP coordinates its implementation in consultation with the HICMR Consultant. Oversight is provided by the IC Committee and the HS IC Manager. IC is a topic in both the orientation and mandatory training program and there is a comprehensive educational program to ensure that relevant staff are appropriately skilled and equipped to prevent and control infections. Targeted AMS training is provided to relevant nursing staff to ensure that they are appropriately skilled to implement the AMS and there are systems in place to conduct AMS activities. The is a COVID Safe Plan that has been successfully implemented and the interventions established to protect patients and staff from being infected are still being monitored and amended as required in alignment with HS corporate and VIC Health policy and recommendations.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Comments
Both the Infection Prevention Officer and the HICMR Consultant manage an extensive audit schedule that covers all aspects of the IC and AM programs at TVC. There are IC related quality improvement projects registered in the Quality Projects Register the most recent focusing on improving the disposal of food waste and introducing new procedures for disposing of pharmaceutical waste. The COVID pandemic is documented in the Risk Register. TVC has recently adopted the electronic MARS Auditing Schedule that includes comprehensive IC and pharmacy audits. These audits are complemented by the quarterly HICMR audits that provide an independent evaluation of the status of ICP at the facility. In response to the pandemic, a COVID Safe Plan was developed with staff and patient educational sessions being conducted to ensure that these stakeholders adopted the mandatory precautions. Visiting by family and friends has not been permitted throughout the pandemic. Data for a number of IC KPIs is collected each quarter and reviewed by the IC and other TVC Committees. It is then forwarded not only to the relevant HS Corporate Officers and Committees but is also placed on hospital Notice Boards, in Newsletters and on the website ensuring that everyone connected with the hospital is aware of its ICP status. The KPIs are benchmarked across the 43 HS hospitals IC Cluster and operational oversight is provided by the HS IC Manager. TVC achieved a 95% compliance rate with all the requirements of the HS IC and Antimicrobial Stewardship (AMS) policies and procedures. This is above benchmark and is a consistent result for TVC. Similarly, a 97% compliance rate was achieved for Hand Hygiene practice. The assessors commend the organisation on the steps taken to maintain full functionality throughout the pandemic.

Rating	Applicable HSF IDs
Met	All

ACTION 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
All new staff and patients are provided with documentation outlining the mandatory actions to be taken whilst working or staying in the TVC facility. These requirements amplify the Vic Health COVID precautions. The assessors noted that all staff and patients consistently wear masks and they wore masks throughout the two day assessment. In addition, social distance was observed and all patients and staff were appropriately vaccinated with a database being maintained. A Consumer Consultant is a member of the IC Committee and in this capacity has recently reviewed and amended the HS IC brochure given to all patients on admission. His contribution was acknowledged by HS Corporate and his amended version is now the official HS version. Another Consumer Consultant is updating the TVC website that contains detailed information for patients and their families about what steps need to be taken when admitted to the hospital. In addition to the above, cough etiquette signage is prominently displayed in reception and communal areas and there is a Receiving Antibiotics Brochure accessible to patients when receiving their medication.

Rating	Applicable HSF IDs
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
The hospital's surveillance strategy for healthcare-associated infections (HAI) and AM is independent in that HICMR and the visiting Pharmacist collect monthly data on HAI and AM respectively. They table their reports at meetings of the IC Committee and Pharmacy Committee respectively. Summaries are provided to the workforce and available to the community on the TVC website. The hospital has a comprehensive COVID surveillance strategy including staff training, a COVID Contact tracing and tracking tool, a COVID Incident Control update email sent to all staff and a COVID Worksafe notification process. Any issues identified by audit are registered in the Risk Register and managed accordingly. Mandatory annual Vic Health reporting of SAP (Golden Staph), MSSA and MRSA with 0% of these infections consistently identified at TVC. Staff Hand Hygiene practice compliance rates of 98% are also consistently reported. Compliance with the requirements of AS 20/01 was verified. The organisation demonstrated compliance with AS20/02.

Rating	Applicable HSF IDs
Met	All

ACTION 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Comments
There is a regularly updated HS policy on Standard and Transmission-based Precautions that applies to TVC. HICMR provides audits and risk assessments to ensure the consistent implementation of policies and ensures that the organisation's policies and processes comply with the Australian Guidelines and relevant jurisdictional laws and policies. TVC uses standard and transmission-based precautions consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. The assessors noted that signage and other resources were consistent with these Australian Guidelines. TVC employs a variety of strategies to prevent infections using gloves and sterile equipment, using specialised disinfectants when cleaning facilities, placing hand sanitizer dispensers in public areas, and providing tailored advice to patients.

Rating	Applicable HSF IDs
Met	All

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Comments
A patient's infection risk history and status are identified and evaluated pre-admission and on admission and re-evaluated as required during their hospital stay. TVC is not equipped to isolate patients with infection risks identified post-admission and these patients are transferred to The Alfred Hospital or to an appropriate alternative. COVID protocols have involved significant environmental changes to optimise the safety of all patients. Environmental Cleaning schedules have been enhanced to ensure an optimally clean and tidy hospital environment and this was confirmed by the assessors during their site inspection.

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
HICMR provides audits and risk assessments to ensure consistent implementation of the HS Standard and Transmission-based Precautions Policy. The HICMR Consultant also conducts scheduled educational sessions on Standard and Transmission-based Precautions to ensure that staff maintain consistently good practice in this area.

Rating	Applicable HSF IDs
Met	All

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Comments
Procedures are available for implementing standard and transmission-based precautions and all staff are provided with education appropriate to their role. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Patients with high-risk infections are not admitted to TVC. A patient's infection history and current status is an important part of the screening process initiated by the Intake Nurse. This process includes a robust COVID screening. Should a staff member become COVID infected whilst working at TVC, there are protocols in place that ensure that the staff member is not at work, contact tracing is undertaken to identify any patients and other staff members who may have become infected and enhanced environmental cleaning of the facility occurs. The hospital has successfully contained any episodes of staff having COVID.

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Patients presenting for admission who have been prescribed antibiotics need to have evidence of their antibiotics being prescribed and/or endorsed by their treating psychiatrist before being admitted. A coloured sticker is applied to the front of the patient's medical record if a risk of any type is identified and the status of this risk is reviewed at every medical and nurse shift handover. Auditing ensures that risk status is routinely documented.

Rating	Applicable HSF IDs
Met	All

ACTION 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Comments
TVC has a comprehensive strategy to prevent and control COVID and similar community infectious diseases impacting the hospital's functionality. This involves staff and patient education, restrictive entry, utilisation of PPE including mandatory mask wearing, high level environmental cleaning and mandatory reporting to VIC Health. There is a protocol to inform a patient's family and carers should a patient become infected and require transfer to a specialist unit.

Rating	Applicable HSF IDs
Met	All

ACTION 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Comments
There is a HS/TVC policy on Hand Hygiene that is consistent with the current National Hand Hygiene Initiative and jurisdictional requirements. The 5 Moments approach is actively promoted and auditors accredited by Hand Hygiene Australia record whether or not staff have performed the approach correctly. Compliance with policy was high and well above the Australian national benchmark of 80%. When audits are conducted each staff group (including doctors, nurses and cleaners) is checked and the compliance rate for each one was very high. Hand Hygiene data is forwarded to the HS corporate IC Manager and IC committee. Hand Hygiene is a standing agenda item at meetings of both the IC Committee and MAC.

Rating	Applicable HSF IDs
Met	All

ACTION 3.11
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation’s policies on aseptic technique
Comments
HS/TVC has a policy on Aseptic Technique and Aseptic Non-Touch Technique (ANTT) is included in the organisation's orientation program and mandatory annual training is provided for all clinicians with optimal participation recorded. Training comprises a PowerPoint presentation and a practical demonstration. ANTT audits are regularly conducted with an AT Guide included in the IC Resource Folder located in each departmental staff base. Audit results are benchmarked and trended to encourage optimal compliance. TVC achieved a 97% compliance score at the last audit. The organisation is compliant with the requirements of Advisory AS20/01.

Rating	Applicable HSF IDs
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
The assessors endorse the rating of this action as Not Applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Comments	
HICMR developed a Construction Risk Assessment Plan and it has been progressively implemented. The plan includes conducting Construction Renovation Audits as required. These audits have been very important during the long period of renovation and construction surrounding the facility. There is also a comprehensive cleaning schedule that not only involves daily cleaning of the patient living and sleeping areas but also scheduled cleaning of exercise equipment and carpets and the disposal of shower curtains as required. The Environmental Services staff receive PPE training and are required to contemporaneously document every area being cleaned. All cleaning schedules are independently audited by the HICMR Consultant. The assessors were impressed with clean and tidy hospital environment and verified the work of the cleaners and their associated All audit are benchmarked and trended to ensure a consistently clean and hygienic environment. The hospital has an external contractor that provides a 24/7 onsite maintenance service with response time aligned to risk status. Waste management is contracted to an external provider that provides the organisation with regular reports of the waste segregation audits they conducted. legionnaires disease testing is regularly conducted. The ESM maintains a database of all essential testing, auditing and cleaning required by government policy and legislation. HICMR provides independent oversight of cleaning with observational audits. All audits conducted routinely achieve benchmark compliance or above.	
Rating	**Applicable HSF IDs**

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Met	All

ACTION 3.14	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	
Comments	
The organisation has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that is responsive to novel infections risks and pandemic planning. All new products are reviewed and assessed for infection related risk. Maintenance is both scheduled and responsive to failure. The Environmental Services Manager (ESM) oversees the cleaning and maintenance of all new and existing equipment, furnishings and fittings. All building issues associated with the new build are being addressed by management. An external contractor is contracted to ensure optimal upkeep of the facility and its contents. There is an annual preventative maintenance Schedule. A separate contractor is responsible for the handling, transporting and storing of linen and separate clean and dirty pathways are in place. The most recent linen cleaning audit achieved a score of 95%. Relevant fridge temperatures are audited daily as per policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Comments
TVC fully implements the HS Workforce Immunisation Policy that is aligned to the Australian Immunisation Handbook. It is mandatory for all TVC staff to be fully immunised against COVID, flu and other potential viruses and infections. In 2019 and 2020 the hospital conducted a massive staff health immunisation campaign that provided staff with vaccinations at no cost. A database was and continues to be maintained by the IPC and this data is overseen by the IC and Leadership Committees. It is regularly updated and audited. In response to the mandatory vaccination requirement three permanent staff resigned and two applications for exemption are currently being considered by management. HICMR provides qualified immunisation providers. At the time of this assessment, 93.1% staff were fully vaccinated.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Comments
There is an annual influenza vaccination program vaccination program is in place. 100% of the workforce are fully vaccinated for COVID-19. There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. Records of workplace allocation include both appointed and locum staff. A tiered approach to outbreak and pandemic planning and management is in place. Apart from the mandatory staff vaccination program TVC conducts regular vaccination fridge audits and arrange to receive as required vaccination fridge service reports.

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Any recommendations are expeditiously addressed. There are also mandatory educational qualifications for the IPC and any other staff conducting the staff vaccination program. HICMR conducts a risk assessment of the staff in the Staff Health Department and a risk assessment is conducted for unvaccinated employees.

Rating	Applicable HSF IDs
Met	All

ACTION 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
Comments
Reusable medical devices, equipment and instruments used at TVC are confined to exercise equipment in the gym and disability aids such as wheelchairs, walking sticks and walkers. There is a HS policy requirement that all this equipment must be cleaned after single use and that this process is documented so that it can be audited. The most recent auditing registered 100% compliance. With respect to the small number of occasions when a patient has contracted COVID, a protocol is in place to trace back to all the places where the patient was in the preceding few days. In such instances any equipment the patient has used is subject to intensive cleaning by staff wearing PPE. TVC is compliant with AS18/07.

ACTION 3.17	
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.18	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement	
Comments	
The organisation has established an Antimicrobial Stewardship (AMS) program that includes an evidence-based AM Restriction Policy, the IPC providing operational management and the Pharmacy Committee and MAC providing governance. The program involves regular auditing, HICMR staff education and evaluation reviews / and reports. The latter include "Drug Use Evaluation AMS Urinary Tract Infection 2022" and "Antimicrobial Report 2022". There is an AMS Brochure provided to each patient when they are admitted. The organisation complies with the requirements of Advisory 18/08 and ACSQHC Fact Sheet 11 (3.15d).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.19	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials	
Comments	
Documentation showed that the AMS included the review of antimicrobial prescribing and use and surveillance data on antimicrobial resistance. The program is evaluated, and performance is monitored with reports provided to clinicians and the governing body. Specifically, the Health Information Manager, a qualified Coder, conducts regular audits of medical records and their codes to check that appropriate antibiotics have been prescribed for infections. Additionally, HICMR audits the medical records and charts of all patients on prescribed antibiotics. Reports of these audits are reviewed and responded to at meetings of the IC Committee, Pharmacy Committee and MAC. This surveillance has resulted in generally appropriate prescribing but occasionally issues are identified (e.g. poor documentation) and registered in the Risk Register. The typical response to these issues of non-compliance is counselling and enhanced education of the involved staff. The requirements of the Advisory AS18/08 have been met.	
Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
The governance of medication management is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles. Medication management is overseen by the Quality Management Committee reporting to the organisation's Medical Advisory Committee, and reports through the governance structure of the organisation to Healthscope corporate management.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Comments	
The organisation monitors the effectiveness of the medication management system through incident reporting using the RiskMan tool. Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified. The completion of a staff self-reflection tool after any medication incident, and a formal review of each medication error to identify contributing factors, are two approaches to learning from incidents experienced and to avoiding further incidents from reoccurring.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation aims to involve patients in their care by providing appropriate information about medications and treatments, fostering shared decision making within the constraints of the person's legal status or capacity. It was clear from the Assessment Team members' attendance at bedside clinical handovers, that patients are generally aware of their medication regimens. Patients interviewed indicated that medication management was discussed with them and that they felt involved in the process and were able to understand the information provided.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
The scope of practice with respect to medication management is defined in policies and procedures and, where appropriate, in position descriptions for clinicians. Where appropriate, Healthscope corporate policies are referred to.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
A best practice medication history (BPMH) is undertaken as soon as practicable and documented in the clinical record. Compliance with completing the BPMH is 100%. During the assessment, Assessors reviewed medical records and the completion of a BPMH, a compliance rate of 100% was also determined.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.06	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	
Interviews with clinicians together with a review of documentation and observations made by the Assessors confirmed that current medications are reviewed for accuracy and congruence with the best possible medication history on presentation and at transition points.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.07	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Comments	
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. Regular audits occur, made easy by the introduction in the organisation of the MARS audit and reporting tool. Records reviewed by members of the Assessment Team confirmed their consistent use. Compliance with documenting medication related alerts is 100%. Should there be a case of non-compliance, immediate education of the staff member is arranged.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.08	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Comments	
Adverse drug reactions are reported through the incident management system and the organisation has a strong culture of reporting incidents and near misses. Medication related incidents are reviewed by the Victorian Clinic's Quality Management Committee and reported to the Medical Advisory Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.09	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
The organisation has established processes for reporting adverse drug reactions to the TGA where required. Prior to the reporting of any drug reactions, consultation and communication occurs with the organisation's contracted Pharmacy provider, HPS Pharmacy, who advise on adverse drug reactions, which are outside the normal and expected drug reactions, ensuring that there are appropriate adverse drug reactions reported to the TGA. To date there have been minimal notifications to the TGA. Incidents reports are generated in RiskMan of any adverse drug reactions, prior to reporting to the TGA.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
The process for indicating the need for a medication review is evidence based and based on risk and clinical need. Responsible clinicians were able to describe this process, how it is documented and how action taken in response to the review are followed though. Clinical documentation reviewed by Assessors supported this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Information for patients on specific medications is available to clinicians and appropriate to the patient population. As part of a patient's first admission, extensive information regarding the medications prescribed is provided to the patient. A copy is maintained on the patient's medical record. The introduction of patient information being available electronically using QR coded lists, has facilitated easier and more convenient access to information. Patients reported being able to understand information about medications that was provided to them.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviews confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. Where requested and at appropriate times, an HPS pharmacist will meet with the patient prior to discharge to provide an opportunity for the patient to raise any questions regarding the prescribed medications. A medication list is provided to patients and to their GP on discharge. Performance is audited and compliance is high.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to information and medication management support tools via Healthscope Corporate and as part of the Victorian Department of Health. Clinicians reported being able to readily access this information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Comments	
The organisation monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage (including cold chain management), distribution and disposal of medications. Incidents are reported through the incident management system to Healthscope Corporate.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Comments	
Interviews with staff and a review of documents supported the Assessors' observation that high risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. There were two reported incidents related to high-risk medications over the previous 12 months.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Comments	
Documentation demonstrates the processes that are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. Members of the multidisciplinary team were able to describe how the organisation's safety and quality systems are used to achieve this. A review of clinical documentation confirms that processes are in place for managing risks associated with comprehensive care. 94% of eligible staff have attended training on comprehensive care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Comments	
Comprehensive care is defined and monitored with a wide range of quality improvement activities being established to improve care including the introduction of quality boards for each ward, and the timely referrals to allied health professionals. The organisation uses patient feedback data and clinical outcomes together with evidenced based practice to support improvements in care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the Assessors how they enthusiastically achieve this, and patients reported that they felt actively engaged in, and informed about their care. A training needs analysis identified from staff feedback their interest in further education on Schema Therapy, TMS, ECT and pharmacological treatment such as DBT, to benefit patient care and support.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.04	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Comments	
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. The organisation operates within their stated scope of service to provide care that best meets the patient's needs and has established protocols and processed for referral where needed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.05	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
Multidisciplinary care is well established, and the role of team members is well defined across the organisation. Staff from all professional groups and disciplines interviewed by the Assessors were able to articulate how multidisciplinary care operates effectively across the organisation. The level of commitment to patient care and teamwork was tangible throughout the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians and patients were able to describe how they interact collaboratively to plan and deliver comprehensive care. This was supported by clinical documentation and witnessed multidisciplinary meetings which confirmed this. The assessors noted high quality teamwork and dedication by all staff to provide optimal care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was sighted in clinical documentation. Regular audits are undertaken to ensure that timely and comprehensive risk screening and patient assessment are completed.	

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
The organisation demonstrated processes that are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in the administrative and clinical information systems including webPAS and in the hard copy medical record. This is audited, with 100% of patients being questioned regarding their cultural origins. Staff were able to describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin, and those who chose not to identify. Three percent (3%) of the population supported by TVC are Aboriginal and Torres Strait Island people.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
The organisation has processes in place to support the completion of advance care plans for patients. While TVC does not provide end-of-life care, policies are available to support the management of advance care plans for patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioral, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the organisation's governance structure. A limited review of clinical documentation by the Assessment Team reinforced this. The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risks. Alerts, allergies and risks are documented in webPAS, and in the hard copy medical record.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Comments	
Clinicians and patients were able to describe the role patients, carers and families play in their care and in determining patient centred goals, and how the organisation aims to best meet their specific needs. A review of clinical documentation by the Assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. Members of the assessment team witnessed interactions between staff and patients that demonstrated this partnership in care and decision making. Carers and families of patients are still not permitted to visit because of the COVID restrictions. Care plans reflect contemporary evidence based best practice principles. The requirements of Advisory AS18/15 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	
Patients were able to articulate their level of engagement in their care and expressed satisfaction that they actively participated in decision making at all points of care and transition. Goals of care are monitored, and care planning modified in response to changes in goals, changing clinical status needs or risk profile.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
Processes to define those patients at the end of their life are in place and staff interviewed were aware of these. The organisation has aligned its processes to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Generally, patients who are at the end of life are not part of the cohort treated at TVC. If patients become seriously ill during their TVC admission and are potentially at the end of life, they are transferred to The Alfred Hospital, consistent with the policies of the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Comments	
The assessors agreed with the rating of Not Applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
It is not the role of the hospital (TVC) staff to assist patients with formulating Advance Care Directives and the organisation's policy 1.1.25 articulates the responsibility that the TVC takes, namely "The Victoria Clinic is responsible to be aware of, and in compliance with, the relevant National and State regulations regarding Advance Care Directives or equivalent Legislation which exist in all State and Territories dealing with the requirements and procedures for ACDs". If a patient has an ACD in place, a copy of any Advance Care Directive is placed in the patient's medical record and a note of its existence made on the Alert Sheet (HMR 000).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
The Assessors agreed with the rating of Not Applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	
The Assessors agreed with the rating of Not Applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
The organisation supports shared decision making about end-of-life care with patients, their carers and families. This is supported by regular communication and documented in the clinical record. Support for decision making is consistent with the National Consensus Statement Essential elements for safe and high-quality end-of-life care. If a patient become seriously ill during their admission and are potentially at the end of life, they are transferred to The Alfred Hospital, consistent with the policies of the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
The organisation has evidence-based policies and procedures for pressure injury prevention and wound management. These are well referenced and regularly reviewed. Nil hospital acquired pressure-injuries were reported over the past 12 months.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Skin inspections are conducted in accordance with policy and compliance and is reported as 100%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Comments
Information is available to patients, their carers / families about pressure injury prevention, this information is in a user-friendly format and staff were able to describe how they would use it. The availability of information using QR codes has facilitated easy access to information about skin integrity and the avoidance of pressure injuries.

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Equipment, products and devices are available to prevent and manage pressure injuries, but with a low (ie zero) cases experienced of such injuries at TVC during the last three years, there were no devices or products in use.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
Evidence based policies and procedures include risk screening and assessment, prevention, harm minimisation and post-falls management. People assessed as a high falls risk are not admitted. Compliance with undertaking falls risk assessments and falls management action plans is audited. Staff were able to describe strategies to minimise harm and clinical documentation reviewed by the assessors supported that this is undertaken comprehensively. Incident data related to falls is reported in RiskMan, analysed and reported through the organisation's governance structure. Falls incident data is benchmarked at corporate HS level. TVC has relatively few registered incidents of falls. There was one recent incident where a patient fell out of bed and an RCA investigation was initiated in response. Governance monitors the effectiveness of falls prevention and management processes to ensure that they are consistent with best-practice guidelines.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
Equipment, devices and strategies to prevent falls and minimise harm from falls are available to staff. The assessors were provided with evidence of the use of these in accordance with the requirements of individual patients as identified on screening.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
Information brochures and falls data are available to patients and their carers / families about falls prevention and risk management strategies. This information has been reviewed and endorsed by Consumer Consultants as having a user-friendly format. TVC has also conducted a major falls prevention quality activity that is described on the TVC website and informs stakeholders and the community of the steps the hospital is talking to prevent falls as well as providing advice to patients and the community about what steps they should take.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Comments
Patients are assessed for nutritional needs and risk of malnutrition. Special dietary plans are established for those who require them and referrals to a dietitian are made where risks are identified. The Assessors saw evidence of screening and referral on review of records, and interviews with staff confirmed their understanding of the process.

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Quality initiatives that have been introduced, such as the availability and changes in menus for patients, and hot breakfasts every Wednesday, are as a result of feedback received from patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Comments	
The organisation provides nutritional support to patients based on their specific needs that are identified through risk screening. Patients who are at risk of malnutrition or who require assistance with eating and / or drinking are provided with assistance. The service has access to specialist dietetic support for those patients identified as at risk or with specific needs. Food and fluid intake is monitored and reported for those patients who are at risk of not having their nutritional needs met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
Cognition impairment screening is undertaken on admission and as required throughout a patient's admission where clinically indicated. Evidence based policies and procedures support staff in developing appropriate management / care plans and these strategies are reviewed for effectiveness. This includes the use and monitoring of medications to ensure compliance with best-practice standards. Screening rates are audited and reported through the organisation's governance structure. The organisation is compliant with the requirements of Advisory 18/12 (1.27b) and ACSQHC Fact Sheet 11 (5.29a).

Rating	Applicable HSF IDs
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
Documentation reviewed shows systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken and compliance with screening is reported at 100%. Of the medical records reviewed by the Assessing Team, 100% of the patients had been screened for cognitive impairment and delirium. Staff were able to describe how they collaborate with patients, carers and families in caring for patients with cognitive impairment.

Rating	Applicable HSF IDs
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Strategies and screening tools are in place to identify patients at risk of self-harm and / or suicide. On identification of patients who may be at risk there are documented intervention strategies that staff were able to articulate. The organisation has access to referral services through immediate contact to the patient's General Practitioner where patients are identified as at risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Where patients have self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and referral service through the patient's Consulting Psychiatrist, General Practitioners and other services accessed by the patient. Staff were able to describe how they would access and use these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used. All staff are educated and deemed competent in de-escalation strategies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
The organisation has strategies and processes in place to identify patients at risk of becoming aggressive including de-escalation strategies. The processes to manage aggression aim to minimise harm to patients, carers, families, staff and visitors and staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression are reported through the organisation's governance structure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Policies and processes are in place to govern and manage the use of both chemical and physical restraint and these include alternative strategies to minimise the use of restraint. The policy is consistent with the legislation and includes processes for reviewing and reporting the use of restraint to the governing body.	

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Comments	
The Assessors agree with the rating of Not Applicable.	
Rating	**Applicable HSF IDs**
NA	All

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies, and also the training requirements / expectation of all staff in support of effective clinical communication. Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
Incidents relating to failure in clinical communication are reported through the incident management system and identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover is monitored through feedback and audit.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation has policies and procedures that support the engagement of patients, their carers and families in their own care and shared decision making. At the time of the Assessment, carers and families were not authorised to visit patients, because of the COVID restrictions. There is a close professional relationship that was demonstrated as existing between the TVC clinical staff and patients, and this was most evident during the clinical handovers that were attended by the Assessing Team. Patients are involved in clinical handover. Patients who were interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes are in place to ensure appropriate identifiers are used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care / patient risk profile are identified. All patient medical records include a photograph of the patient for identification purposes. This is subject to patient consent. 100% of TVC patients include a photograph in the record. Documentation viewed by the Assessors supported the use of specified identifiers in these situations.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.05	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
The organisation has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the Assessors witnessed this when observing the patient journey and during bedside handover.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.06	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
The Assessors noted the use of approved patient identifiers as noted in Action 6.5. Additionally, processes are in place for procedural time-out, and this is documented and audited, with compliance at 100%. A limited review of clinical documentation supported these findings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.07	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient, and the clinicians involved in handover. Compliance with these requirements is audited and reported and the current compliance rate is 90%. Staff could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover. This supported the clinical handovers witnessed by members of the Assessment Team. There was a patient without an identification band in place, however, the patient was well known to the two clinical staff, and the medical record being used for handover included the patient's photograph for identification. The patient confirmed the three identifiers that were in the record.	
Suggestion(s) for Improvement	
Staff are required to continually check that patient armbands are in place, to ensure consistency in the availability of armband identification at all times of the provision of care, and including during times of transition care, e.g. TMS treatment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.08	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Comments	
The assessment team witnessed clinical handover that was structured using the ISBAR format, and effectively engaged with patients to define the goals of care and decision making. The carers and families of the patient were not permitted to visit patients during the Assessment, as a result of the COVID restrictions. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making, when possible. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learn shared and disseminated.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.09	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Comments	
The organisation has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Both patients and staff were able to describe to the Assessors how this worked and how patients, their carers and families were involved when they wanted and/or needed to be. Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers, and families to directly communicate critical information and risks about care. Clinicians and patients interviewed confirmed this and the Assessors observed information available to support and facilitate this process. The Victoria Clinic Ways to Wellness approach and the use of three Books to inform patients what to expect during their treatment program, encourages patients to maintain a diary and their reflections. This is a commendable approach to improving communications between patients and clinicians.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
Clinical documentation reviewed by the Assessors confirmed compliance with the organisation's process to ensure that complete, accurate and up to date information is recorded in the healthcare record. Members of the clinical team could describe this process. Clinical handover audits are scheduled twice a year, and Observation chart audits occur quarterly. However, audits have been scheduled more regularly in a focused approach to approve the quality and content of clinical documentation.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.04	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
Policies and procedures are in place to recognise and respond to acute deterioration and staff were able to describe their role for such events. Risks and training needs are identified, and training records were made available to members of the Assessment Team.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
Systems are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration and this is reported through the Quality Committee that meets monthly, to the quarterly meeting of the Medical Advisory Committee. Reporting also occurs to clinicians for the purposes of clinical review. In response to incidents related to clinical deterioration, improvements have been made including increasing the awareness of patients to the brochure providing information and the process for escalating care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Documents reviewed show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. This process includes involving patients, meeting their information needs and shared decision making. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration. The Assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
A patient's vital signs are monitored in accordance with the policy using the Healthscope physical observation chart. A review of clinical documentations supported this. Observations are undertaken in response to each patient's individual circumstances, and the chart highlights potential clinical deterioration and the need for escalation / intervention. There is constant observation occurring of TVC patients, with hourly observations maintained for high-risk patients. In a review by the Assessing Team of medical records, in all cases, observation charts were completed consistent with the individual requirements of that patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
Policies and procedures support staff in identifying acute deterioration in a patient's mental state including the risk of delirium. Assessment and care planning documentation reviewed by the Assessors also supported that assessment drives the establishment of individualised and appropriate management plans, for patients with acute mental deterioration and / or delirium. Clinical documentation is audited regularly and compliance with cognition screening is reported as being high and compliant with individual patient's needs. Processes are in place to support timely communication between members of the treating team and the patient, and by carers and family members when COVID restrictions are lifted, and visitors are once again allowed in TVC. The requirements of Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The organisation monitors performance of the identification and management of acute physiological and mental status, pain and / or distress, and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the Assessment Team, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff, in the management and escalation of clinical deterioration, and that they are current and reference best-practice.

ACTION 8.06	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
The requirements of Advisory AS 19/01 have been met (8.6 b, c, d, e).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, and patients confirmed this, and observation of the escalation system used across the organisation further supported this process. The Assessing Team was unable to interview carers because of the COVID restrictions and visitors not permitted to be in TVC.	
Suggestion(s) for Improvement	
When the COVID restrictions are lifted and visitors are able to return to TVC, re-education should occur ensuring that families are familiar with the signs of deterioration and the process to follow should this occur.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Comments
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and the Assessors were provided with documentation to support the evaluation of these processes which are reported through the Quality Management Committee. Where a patient's condition deteriorates, a Code Blue or Grey is called, and attendance by the rapid response team occurs. A patient's treating doctor is informed of any deterioration, and handover notes include clear monitoring plans and the frequency of observations to occur. Staff are aware regarding when they should call 000.

Rating	Applicable HSF IDs
Met	All

ACTION 8.09
The workforce uses the recognition and response systems to escalate care
Comments
Staff were able to describe the systems in place to escalate care consistent with the organisations policy. Reports provided to the Assessment team and reported through the Quality Management Committee confirmed the effectiveness of these processes.

Rating	Applicable HSF IDs
Met	All

ACTION 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Comments
Education is provided to clinicians to support the timely and effective management of patients who deteriorate acutely. Compliance with BLS training is reported as 72%.

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Two staff have also been trained in ALS, in preparation for ECT treatment being introduced when hospital staff move to the new TVC building. The organisation has been concerned with the staff's preparedness for patient deterioration and a mock code was conducted in the hospital's two wards during July. A full analysis was carried out by clinical staff to identify any weaknesses in the outcomes. Training was arranged to address concerns. Further Rapid Response Systems reviews have been scheduled when TVC move to the new building, and to confirm the effectiveness of the July exercise.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competencies. Training records were made available to the Assessors. Where access to clinicians with advanced life support is not available 24/7, staff are familiar with the contents of TVC policy: Escalation of Care – The Deteriorating Patient: Policy 1.2.23, and the action to be taken. Staff were able to describe the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referrals to relevant services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to members of the Assessment Team and the effectiveness of escalation of care processes are monitored through the Quality Management Committee, with quarterly reports made to the Medical Advisory Committee.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil