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# NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

## *Final Report*

Holmesglen Private Hospital

Moorabbin, VIC

Organisation Code: 226820
Health Service Facility ID: 101057
Assessment Date: 15-17 February 2022

Accreditation Cycle: 1

# Contents

# Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

# Executive Summary

Holmesglen Private Hospital underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 15/02/2022 to 17/02/2022. The NS2.1 OWA required three assessors for a period of three days. Holmesglen Private Hospital is a private health service, and it was last assessed from 21/03/2018 to 23/03/2018.

Holmesglen Private Hospital (HGPH) is a state-of-the-art private hospital in Melbourne's south. It has a medical/surgical and oncology case mix, with imaging services including an angiography suite augmented by an Emergency Department managed by a contracted VMO FACEM team, and an ICU/CCU which provides high level care to patients undergoing major surgery and other medical conditions. HGPH is very well supported by Healthscope, which is increasingly standardising its processes to ensure consistency of safety and quality across the entire organisation. Hospital performance is monitored locally and reported via key performance indicators across an expansive range of indicators to the Healthscope Board. Assessors found the organisation to be well led by an enthusiastic leadership team which is committed to maintaining a well-managed, safe organisation within a culture of continuous quality improvement.

Assessors noted that the hospital is currently not functioning to full capacity because of legislative requirements to reduce surgical services for the state of Victoria to cope with high numbers of Covid patients.

The organisation's risk management and quality frameworks are robust and the attention to quality and safety is much in evidence. HGPH clearly understands the importance of audit and evaluation which has led to ongoing quality improvement across the eight National Standards in Version 2. Assessors noted the support provided by Healthscope Corporate to achieve the levels of monitoring and high-quality outcomes observed.

In preparation for assessment, the organisation provided very comprehensive self-assessment documentation. On site, assessors visited all clinical areas, and met with the HGPH leadership team and numerous clinical and non-clinical staff. Assessors also met with the current Chair of the Medical Advisory Committee and three MAC members. Assessors had easy access to policies, procedures and extensive documentation. Assessors also spoke to many patients, who all felt actively involved in their care, and well cared for during their admission. Assessors completed several patient and process journeys to learn more about the hospital's safety systems and ran a number of high-risk scenarios past staff. All staff involved were able to articulate processes in place to deal with such scenarios. Assessors also had the opportunity to observe the organisation's responsiveness to emerging issues when some adaptations were required to medication safety during the assessment period.

A synopsis of the eight standards is now provided:

HGPH has robust governance with the active support of Healthscope through its policies, procedures and monitoring procedures. Risks are closely monitored and managed. There is a strong commitment to patient-centred care and partnering with consumers.

Quality improvement is embedded, aligned with forcing factors such as action plan reviews. Staff are trained in safety and quality and understand their roles in this regard. Management of credentialling and scope of practice is meticulous and evidence-based care is being given increasing priority. It was pleasing to see clinical indicators monitored, as well as the implementation of relevant ACSQHC Clinical Care Standards. A safe environment is maintained. The small proportion of Aboriginal patients are respectfully and sensitively cared for and offered access to local Aboriginal support services through the local Council if they wish.

The Healthscope Consumer Advisory Committee provides a governance and reporting framework for all Healthscope hospitals and supports sites to participate in the national meetings that oversee and monitor consumer participation. There is a commitment to engaging with consumers to participate in planning of services, to oversee patient information and to monitor and evaluate clinical outcome measures.

At the local Holmesglen level, Covid has impacted on consumer participation over recent years and the Quality and Executive team have instituted a renewal process to bring consumers on board for the consumer focus committee. The plans for inclusion are encouraged, including the plans to engage consumers in the strategic plans/projects for the organisation.

Healthcare rights and responsibilities are included in the Holmesglen patient compendium and pamphlets provided to patients in DOSA. It was apparent to the assessors that there is commitment to partnering with consumers in their own care, which was reflected in the bedside handovers Assessors observed and the patient journeys followed by Assessors from DOSA admission through theatre and recovery.

The nursing staff culture observed was respectful, caring and inclusive, including tailored approaches for special patient needs such as cognitive impairment and caring for children. When consumers have reviewed the patient information brochures for accessibility and clarity, the consumer tick is applied. There is a process for access to interpreters and to access brochures in the common languages reflective of the local demographics – primarily Greek, Italian, Chinese and Russian.

HGPH is partnering with the Kingston council Aboriginal and Torres Strait Islander support services to refer patients for support. To ensure appropriate access, a local survey has commenced to ascertain why a number of patients are not identifying at all.

In regard to infection prevention and management, the clinical governance and reporting framework is an established Healthscope system that has been rolled out to sites with the capacity to adapt to local conditions. The support from the external HICMR consultancy includes a manual to guide compliance with the IPC standard as well as audit tools, monitoring support and a gap analysis against the standard. The National IPC committee has a standardised and structured process for reporting and monitoring the sites compliance with the IPC standard.

It was noted by the Assessors that the Covid screening process at the front reception could be improved. This was rectified during survey to ensure that all visitors coming through the front reception were monitored. There are robust processes for Covid screening in Emergency Department and for elective surgery and admissions.

Surveillance and processes for transmission-based precautions are compliant with the requirements of the standard, well managed and maintained. There is compliance with AS 4187 and the associated Advisory.

Low compliance with AMS guidelines has been addressed by several initiatives with nursing and medical staff implementing a “stop and review” system including stickers in the histories. The MAC Chair has given medical staff notice of the requirements to comply and we would expect with the maintenance of these initiatives there will be improvements over time. The sepsis pathway has been implemented and supported by MAC.

Medication safety is generally well managed with good governance which includes a comprehensive suite of policies and procedures. HPS Pharmacy provides the pharmacy services. Numerous audits are conducted to monitor the efficacy of the system, with action plans in place to address deficiencies.

There is safe and secure storage and distribution of medicines, and a strong focus on high-risk medicines. There are suggestions for strengthening some of the clinical activities, including obtaining the best possible medication history (BPMH) and benchmarking pharmacy resources across peer hospitals in Healthscope regarding the taking of BPMH. There is a recommendation made to improve medical documentation on the National Standard Medication Chart (NSMC).

HGPH, as part of Healthscope, has well developed systems and processes in place to support the provision of effective comprehensive care across its range of clinical services. The HGPH Comprehensive Care Committee plays a key governance oversight role. The Committee monitors and reviews the wide range of comprehensive care related activities that are being undertaken throughout the organisation. HGPH demonstrated a strong culture of patient-centred care, which has been reinforced by the back-to-bedside and back-to-basics initiatives. HGPH places a high emphasis on risk minimisation and a team approach to care.

A strong education and training program is in place, covering a range of comprehensive care related topics. This includes a focus on training in the management of delirium and behaviours of concern, and the prevention self-harm and suicide.

HGPH has undertaken a considerable amount of work to ensure that communicating for safety systems are embedded throughout the organisation. Processes to ensure effective transfer of care in a wide range of circumstances are in place. HGPH has an emphasis on shared decision making and partnering with patients and their families in the provision of care.

Blood is well managed with comprehensive policies and protocols, and records well documented. Redesign of the Blood and Blood Products prescription and Transfusion Record has resulted in succinct, comprehensive information being available on the one page.

A Massive Transfusion Resource Folder was introduced in 2020. Strategies have been put in place to optimise patients' blood requirements. Emergency supplies are rotated by the private pathology provider for use elsewhere, keeping wastage to a minimum.

The Transfusion (Blood) Committee is Advisory to the Hospital Executive. This Committee monitors and evaluates clinical outcomes to make appropriate recommendations. It fosters and facilitates the clinical governance and accountability for the standards and performance in relation to National Standard 7: Blood and Blood Products. The committee minutes had evidence of broad representation across key clinical areas. Standard committee agenda items included advancing consumer brochures with the Consumer Advisory Committee, monitoring consumer satisfaction, compliments and complaints.

Clinical incidents are registered on RiskMan and a comprehensive report is undertaken. The Transfusion Committee monitors these reports. Staff compliance with BloodSafe education/training modules is monitored. Audits of prescribing and clinical use of blood and blood products indicate overprescribing with normal haemoglobin levels, however this does not consider the day infusion centre, where chronic and palliative patients require multiple transfusions and prescribing outside the acute guidelines. On audit, compliance with documentation of consent shows room for improvement. The MAC newsletter 2021 Q3 included a reminder to VMOs to ensure completion

Blood management incident reports are monitored and acted on. A recent post-operative haemorrhage incident review revealed opportunities for improvement in the activation of the Massive Blood Transfusion Protocol. Improvements include the development of a local HGPH policy as an Addendum to the Healthscope policy, including a flowchart.

HGPH has systems and processes in place to rapidly respond when patients experience acute physical or mental deterioration. This includes the activation of rapid response teams that are made up of well-trained clinicians. All rapid response activations are thoroughly reviewed with a focus on improving patient outcome. The HGPH Clinical Deterioration Committee plays a key governance role regarding all aspects of recognising and responding to acute deterioration. The HGPH Mortality and Morbidity Committee also plays an important monitoring role.

In conclusion, assessors noted that HGPH staff were uniformly very proud of their organisation and have numerous opportunities for education, training and professional development, where compliance in mandatory training is very high. It is obvious that Holmesglen Private Hospital has worked very hard and there has been steady improvement in systems and processes associated with the eight National Standards, despite the turmoil created by now nearly two years of COVID-19 pandemic.

Assessors have rated all actions as Met – with a single recommendation regarding deficiencies in doctor documentation on the National Standard Medication Chart.

## Summary of Results

At Holmesglen Private Hospital's Organisation-Wide Assessment one Action was rated Met with Recommendation across 8 Standards. The following table identifies the Action that was rated Met with Recommendation and lists the facilities to which the rating applies.

## Actions Rated Met with Recommendations

| Facilities (HSF IDs) | NS2.1 OWA 15/02/2022 - 17/02/2022 |
|---|---|
| | MwR |
| Holmesglen Private Hospital-101057 | 4.02 |

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

# Sites for Assessment
# Holmesglen Private Hospital

| Site | HSFID | Address | Visited |
|---|---|---|---|
| Holmesglen Private Hospital | 101057 | 490 South Road MOORABBIN VIC 3189 | 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:<br>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** |
| Holmesglen Private Hospital (HGPH) is one of 44 Healthscope hospitals throughout Australia. The Healthscope Board (along with the Healthscope Advisory Board which provides expert clinical guidance to the Board) demonstrates a high-level commitment to the maintenance of a safety and quality improvement culture from which HGPH benefits through extensive policy support and a robust monitoring framework. Safety and quality are led by the Board sub-committee, the Clinical Quality Committee, which considers all hospitals' quality and safety outcomes, including the review of action plans where outcomes do not meet established benchmarks. The OneHealthscope 2025 Strategy makes clear Healthscope's commitment to safety and quality through its platforms to improve the human experience (for patients, workforce, and partners) and its investment in infrastructure. This has been developed through extensive consultation and is now widely communicated to all stakeholders via a range of hard copy and electronic mechanisms. The Strategy has been implemented at HGPH.<br><br>The commitment to partnering with patients, carers and consumers is obvious, with consumers active participants on all relevant committees at both local hospital and corporate levels. There is an extensive network of feedback mechanisms to obtain, and act on, consumer perspectives, which is replicated across all hospital sites and in which the Board takes great interest. Consumer partnership is described in policy to assist hospitals to meet their obligations in this regard.<br><br>The governing body has a clinical governance framework which informs all hospital clinical governance plans, including that of HGPH. All are formally endorsed.<br>As stated, a robust monitoring framework is in place whereby hospitals report monthly against an established set of quality and safety performance indicators, which are compared to benchmarks. Any deviation from benchmarks requires explanation and an action plan which is monitored closely by the Healthscope Clinical Quality Committee. The monitoring process includes assurance that the roles and responsibilities of all Healthscope employees are clearly defined and regularly reviewed.<br><br>A comprehensive committee structure provides a pathway for monitoring actions taken as a result of analysis of clinical incidents. All sentinel events are reported immediately to the Healthscope Chief Executive Officer (CEO) who informs the Board in a timely way if required. |

| ACTION 1.01 |
|---|
| The governing body:<br>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 |
| At HGPH, the clinical committee structure now reflects the National Standards with terms of reference which define each committee's role in operationalising and monitoring the Standards. Over time, a number of working parties created to oversee specific clinical elements have been incorporated into an overarching Standard Five Comprehensive Care Committee. The current reporting structure demonstrated effective governance over each Committee internally and to the Healthscope governing body through key performance indicators and reporting by exception for defined events. |

| 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** |
| Healthscope is committed to addressing the needs of Aboriginal and Torres Strait Islander people through the establishment of safety and quality priorities. It has developed the Aboriginal and Torres Strait Islander Engagement Plan 2021 monitored by the Reconciliation Working Group. The Engagement Plan forms the basis for all related local hospital initiatives including those at HGPH which has developed its own Engagement Plan. HGPH acknowledges its location on the land of the Boon Wurrung people of the Kulin nation, and engages with the local Council's Aboriginal Liaison Officer should patients identifying as Aboriginal require additional support.<br><br>All Healthscope staff undertake mandatory online learning related to cultural competence and Healthscope has significant resources available on HINT to support strategies to improve ATSI health and wellbeing. The hospital's activities related to care of its very small numbers of Aboriginal patients are reported to the governing body through performance indicators related to the Engagement Plan. |

| 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** |
| HGPH has a comprehensive clinical governance process maintained in accordance with its obligations to its parent company Healthscope, the overarching clinical governance framework of which sets out the requirements for each of its 44 hospitals.<br><br>The Clinical Governance Framework guides HGPH in those systems in place which measure and monitor the safety and quality process. This includes systems of control such as robust reporting requirements with defined performance indicators benchmarked against peer hospitals in the group, and comprehensive reviews of clinical incidents, particularly those which meet the criteria for Healthscope-defined sentinel events. The organisation was able to provide many examples of improvements in safety and quality, many of which have been achieved through the metamorphosis and relocation of Como Private Hospital to a new, larger facility in Melbourne's southern suburbs.<br><br>Accompanying this monitoring process is company-wide Shared Learnings Program, whereby all relevant hospitals must demonstrate that learnings from serious events at like hospitals are applied at their own, thereby avoiding or mitigating risks which may not previously have been identified.<br><br>The Healthscope Quality and Risk Plan ensures Healthscope incorporates healthcare safety and quality into its business decision making, being aligned to the Healthscope Strategic Plan. All HGPH's quality and safety initiatives reflect this process in its own local Clinical Governance Safety and Quality and Strategic Plans which is readily available for all staff and medical officers.<br><br>HGPH submits quarterly clinical Quality Key Performance Indicators (KPIs) to Healthscope for review by the Clinical Quality Committee, with key issues added to the Executive and Board agendas as required. Healthscope strategic planning ensures meaningful partnerships with consumers occurs.<br><br>A newly formed National MAC (Medical Advisory Committee) has been developed to advise on issues relating to medical governance, an initiative which should strengthen the current Clinical Governance Framework. The current chair of the HGPH MAC is a member of the inaugural National MAC. |

| 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** |
| Assessors were provided with evidence that HGPH continues to monitor the strategies in place to meet the very small percentage of those patients currently identifying as being of Aboriginal and / or Torres Strait Islander background through connections with the local Council's Aboriginal liaison service.<br><br>The hospital acknowledges its local first nations people in all activities and celebrates both NAIDOC Week and National Reconciliation Week. Many staff have completed cultural awareness and competence training and have created a welcoming environment for Aboriginal consumers, in accordance with principles set by the Healthscope Board. |

| 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** |
| HGPH considers the safety and quality of patient's health care in business decision making, aligning it with the Healthscope Quality and Risk Plan and the HGPH Safety and Quality and Strategic Plans.<br><br>The primary example of this is the purpose-built new facility co-located with a post-secondary education facility which educates a large number of nursing and allied health professionals. New facilities include a busy Emergency Department, cardiac services supported by an interventional cardiology suite, and Intensive Care Unit and a new Operating Suite.<br><br>The building has been future proofed through the incorporation of several building shells (currently empty) which can readily be converted to additional services as need arises. Such initiatives have been implemented using the consumer experience to deliver and improve safe and effective care and services. Over 70% of patient wards are single rooms, reflecting consumer preferences. |

| 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** | |
| The HGPH Executive team has a strong commitment to safety and quality, supporting clinicians to perform their safety and quality roles and responsibilities. Safety and quality information is visible throughout the organisation and underpins the training/education program. Assessors met with the leadership team, managers, clinical staff and patients, and through conversations with them and the review of an extensive range of safety and quality documentation, were satisfied that this commitment permeates throughout the organisation. Notwithstanding, assessors noted that the transition from the smaller Como Private Hospital to the new large, high tech, increasingly busy HGPH continues to evolve and requires ongoing education, training and support.<br><br>In compliance with Healthscope human resources and safety/quality policy, HGPH has position descriptions for the workforce which includes responsibility for quality and safety based on the corporate template. These are recorded and tracked in conjunction with staff performance reviews. Medical Officers are bound by Healthscope By-laws 2019. These By-laws assist VMOs to operate within a clinical governance framework which is monitored through the Medical Advisory Committee and craft group meetings. | |
| **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** | |
| Healthscope has an extensive range of standardised policies by which HGPH is governed, and with which it must comply. Included in the system is a process whereby if Healthscope policy is not available, a local policy/standard operating procedure (SOP) can be developed provided it meets Healthscope criteria.<br><br>In regard to infection control, Healthscope is guided by a private company (HICMR) whose policies comprehensively govern infection control at HGPH.<br>The Healthscope Document Controller maintains the policy review process and monitors for legislative, regulatory and jurisdictional compliance. The Document Controller issues new or updated policies monthly with these distributed throughout the hospital by the HGPH Quality Manager. In 2020 Healthscope listed its high-risk policies with compliance audited via incident review, near misses and feedback.<br><br>An example of a risk management approach was provided whereby, during the first months of the Covid pandemic, multiple related policies with frequent amendments were being distributed by the jurisdiction. To ensure that staff kept abreast of, and complied with, these many changes, all other policies coming up for renewal were risk assessed and review delayed where this could safely occur.<br><br>Compliance with policies is measured through an extensive audit framework (where levels of compliance are generally high) and through analysis of all incidents to identify policy breaches and effect change through well-monitored action plans. | |
| **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** |
| An effective system is in place to use organisation-wide quality improvement systems. Healthscope has high expectations regarding safety and quality, defining priorities through its strategic planning and creating a rigorous framework for measuring, monitoring and reporting on performance and outcomes.<br><br>HGPH complies with corporate policy through monthly data uploads to the corporate Clinical Governance (CG) team. The CG team reviews the hospital's data and formats it into the reporting template which contains benchmarked targets. Deviations from benchmarks require an action plan from HGPH which is monitored by the CG team. Several examples of how this process functions were provided to assessors.<br><br>Assessors also observed how HGPH's action plans are put into place through its relevant committees (such as the Infection Control Committee and the Medication Safety Committee) and monitored by the Quality and Risk Committee. This process assists clinical staff to make required improvements and to measure their effects through the local audit process.<br><br>HGPH uses other mechanisms to monitor quality improvements in addition to required performance indicators. It carefully analyses incidents reported through RiskMan, the incident management system, for trends and improvement opportunities as well as reviewing patient/consumer feedback. If issues are identified, they are subject to the same monitoring process through action plans.<br><br>As a new hospital HGPH is still building its consumer framework which has been de-railed by the Covid pandemic for the last two years. It has a single enthusiastic consumer and others in the process of induction. Active discussions are underway regarding their membership of relevant Committees and assessors support the organisation's plan to involve them at the level of the Quality and Risk Committee and the Patient Care Review Committee.<br><br>Clinical staff were able to articulate many examples of local quality improvement initiatives including some at ward level. Many of these were on display on Safety and Quality Boards throughout the organisation in patient and non-clinical areas for wide dissemination. |

| 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** |
| A comprehensive reporting framework for matters relating to safety and quality systems is in place across all Healthscope hospitals in accordance with policy. Outcomes are benchmarked against like hospitals so that shared learnings can be used to improve performance. All reporting on safety and quality is timely and reports are provided to the Healthscope governing body through its sub-committee, the Clinical Quality Committee. Consumers are also represented on the Healthscope Clinical Quality Committee and are members of the local committee at HGPH.<br><br>Safety and Quality Boards located in public areas for consumers to read provide a mechanism for feeding back to patients. Consumers and other relevant health service organisations can also easily access safety and quality outcomes via the MyHealthscope website.<br><br>There is an extensive range of quality and safety items/reports discussed at ward/departmental meetings, at craft group meetings and at the hospital's committees. The Medical Advisory Committee (MAC) also reviews outcomes and is a platform to keep Visiting Medical Officers (VMOs) up to date with the hospital's performance across its many indicators.<br><br>The MAC at HGPH is active and engaged, taking great interest in safety and quality, particularly as it relates to medical care. Many members have transitioned from the old Como Private Hospital era to the new HGPH and are thus a valuable resource regarding the history of the organisation.<br><br>The hospital sends data to a number of sources where it participates in external benchmarking and receives reports in return. These include VICNISS (Infection Control) and ANZIC.<br><br>There is work underway through Health Information Services to ensure the accuracy, validity and comprehensiveness of information to increase the organisation's confidence in data quality. This applies to validation of hospital acquired complications (HACs) data. |

| 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** |
| HGPH complies with the Healthscope Risk Management Framework and related policies. It has an integrated risk register, from which risks are reviewed at a frequency according to the level of residual risk or incident occurrence. KPIs in place for serious risks to make sure monitoring of such risks is regular and effective.<br><br>Healthscope has two layers of Risk Register: Corporate and Hospital risk registers. The Hospital risk registers are co-ordinated nationally so any new risks arising from sentinel events or other issues are added to all risk registers nationally.<br><br>Risk management policies and the Risk Management Framework are regularly reviewed to ensure they reflect best practice and they are adjusted to maintain the efficacy of the risk management system. There are also policies that address specific risks, such as workplace health & safety, fraud prevention, infection control, bullying, and emergency procedures. These policies guide staff on risk identification, assessment, and reporting.<br><br>There is a range of business continuity and emergency response policies available to the organisation. These policies set out staff responsibilities if their work area is impacted by internal or external issues.<br><br>Examination of the hospital risk register by assessors confirms that the organisation identifies and manages its risks well, taking action to mitigate them wherever possible. Several examples were provided by both clinical and non-clinical personnel, suggesting an organisation-wide approach.<br><br>Staff learn about risk at orientation supplemented by ongoing education. Managers receive specific education in this regard. A ‘train the trainer’ model is in place overseen by the National Clinical Risk Systems Manager. The workforce is notified of risks (and their management) through many communication streams. This includes via HINT intranet access, organisation-wide emails, ward meetings, through attendance at committee meetings and through National Webex teams. Several examples of the effective management of risks were provided to assessors. |

| 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** |
| Healthscope dictates its hospitals' approach to incident management and open disclosure through a range of related policies. RiskMan is the incident management system which allows all staff to report an incident, from where it is analysed, trended and reported. Assessors found that the workforce is well-supported to recognise and report incidents via a range of mechanisms, including orientation, ongoing training and assistance from the Quality Manager. All staff were able to describe how they would proceed should an incident be identified locally.<br><br>The Quality Manager reviews all incidents at hospital level and reports trends through KPIs to Healthscope. Serious incidents such as sentinel events are elevated via the Healthscope hierarchy to the Board sub-committee, the Clinical Care Committee. All incidents are reviewed and adhere to the requirements of the Healthscope high level incident policy. Consideration is given through the review process to adding risks identified via incidents to the risk register. Examples of this were provided.<br><br>Recommendations arising from incident reviews are captured and monitored either by relevant committees (e.g. Infection Control or Medication Safety) or action plans overseen by the hospital Quality and Risk Committee. Clinical staff are kept up to date with progress of reviews and any outcomes, which may necessitate a hospital-wide education program, or a local response. The analysis and recommendations arising from incident management have been used to improve systems and processes. Several examples were provided to support this statement.<br><br>Reporting areas of concern by patients, carers and families is encouraged and HGPH provides information for patients, carers and families with Rights and Responsibilities posters and brochures displayed throughout the hospital. There is also a Healthscope website online contact page, and any relevant reporting to HGPH would be sent to the HGPH General Manager (GM) for review.<br><br>Staff can provide feedback about the incident management process and in turn receive feedback about RCA outcomes and incident trends at ward/departmental meetings. VMOs receive information through the MAC minutes, craft group meetings and general emails. Each clinical area has a Safety and Quality board to display data related to their rate of incidents.<br><br>Several amendments have been made over time to RiskMan to improve its efficacy. Several changes, and the reasons behind them, were explained to assessors as evidence of improvements made. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.12 | |
|---|---|
| The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes | |
| **Comments** | |
| The Healthscope Open Disclosure process is consistent with the Australian Open Disclosure Framework and requirements are clearly defined in Healthscope policy. HGPH complies with the Healthscope policy and reports on its outcomes regarding staff training. Open disclosure is recorded when it is undertaken as a result of serious incidents.<br><br>There is mandated training in the general principles of open disclosure for clinical staff, and more advanced education for senior staff and VMOs who may be called upon to provide formal open disclosure as part of the incident analysis process.<br><br>Several initiatives have been undertaken to improve the efficacy of the open disclosure process and include changes to the training/education process, amendments to RiskMan to better capture how/when open disclosure occurred, and through the Healthscope Shared Learnings program. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.13 |
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| 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** |
| HGPH actively encourages feedback from patients, carers and families. Feedback is sought via electronic survey using questions based on the new Australian Patient Experience Question Set developed by the ACSQHC, although all avenues of feedback encouraged, whether verbally or in writing directly to the HGPH GM. The most common method of feedback is now via electronic means.<br><br>The Healthscope Board promotes the 'Back to Bedside project', a quality improvement initiative which promotes early and regular feedback at the bedside, increasing opportunities to address issues before they become more serious, avoiding escalation through perceived inaction. All nursing staff were aware of, and participate in, this initiative and were able to see its value. They were able to provide several examples to assessors of small but effective actions taken as a result of the process. Managers and executives also conduct 'rounds' to gather feedback and similarly act immediately to better manage patient perceptions of their care using the project's toolkit.<br><br>All feedback and complaints are formally reviewed through RiskMan, trended and actioned in a timely manner. Trends in complaints are used to improve safety and quality systems and the organisation was able to provide evidence of where this has occurred.<br><br>Patient feedback, however, is in the main very positive, rating care provision as good or very good 95% of the time.<br><br>HGPH staff are offered opportunities to provide feedback regarding safety and quality systems through the regular Healthscope Employee Experience survey, debriefing following serious incidents, and the use of reflection tools following incidents. VMOs are also surveyed to ascertain their views.<br><br>Action is taken based on results, with many examples provided to assessors. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.14 |
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| 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** |
| HGPH is supported in regard to complaints management via Healthscope Feedback and Complaints Management policies, and their related procedures. Consumers are encouraged to provide feedback to HGPH, including the making of a complaint if systems outlined in 1.13 to address feedback are insufficient. Managers at HGPH monitor the Qualtrics webpage as a common source of complaints; those coming through the Healthscope 'Contact Us' website are also forwarded to the HGPH General Manager for response and action. Patients may also complain to nurses and Nurse Unit Managers, and this is managed under the 'Back to Bedside' process, while the Managers' rounding process may also elicit issues about which a patient may wish to complain. Complaints through other sources such as letters and phone calls are received, although are less common now that electronic methods are ubiquitous.<br><br>All formal complaints received are entered into the feedback section in RiskMan, and monitored to document and track the organisational response to patient complaints. HGPH's complaint response times are reported via Quality KPIs to the governing body (which may also be provided with detail about complaints of a serious nature). Current compliance with timeliness of response is at 100%.<br><br>Feedback on complaints management is provided to patients and staff through displays on Safety and Quality Boards throughout the hospital, to the MAC and to the wider public through the MyHealthscope website. Ward staff now have access to the Qualtrics dashboard for the purpose of early response to issues. Complaints are also discussed in detail at ward/departmental meetings where the requirements of the Back to Bedside program are reinforced. Consumers are further involved through their representation on the HGPH Clinical Governance Committee.<br><br>The complaints management system is regularly reviewed and has improved over time through amendments to the RiskMan platform to better capture complaint data and through displays of complaint outcomes for patients and staff to note. Managers have access to a range of corporate supports, including the National Clinical Risk Manager, for advice and direction as required to effectively address serious or complex complaints, and to ensure risks arising from complaints are appropriately managed.<br><br>Conversations with several patients during the assessment suggested that overall patients are very happy with facilities, meals and care provided at HGPH. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.15 |
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| 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 Healthscope policy: Diversity and Inclusion governs the HGPH approach to diversity and its management of its local high-risk population. The hospital uses demographic data from the City of Kingston LGA to inform its position and follows policy regarding asking all patients whether they identify as being of Aboriginal and / or Torres Strait Islander descent so that supports can be tailored if required.<br><br>Information regarding interpreter needs is sought on pre-admission or admission as the local area has specific nationalities located in the area. Relevant multilingual information is readily available.<br><br>Information gained through ongoing analysis converts to changes and updates to service provision through the strategic planning process, and is operationalised through, for example, the provision of numerous aids to reduce pressure injuries, falls, malnutrition and better manage cognitive impairment for the frail and elderly who attend HGPH for treatment.<br><br>Pre-admission screening also captures patients likely to be at higher risk of harm, from where they may be referred to the Pre-admission Clinic for individualised care planning.<br><br>Alerts arising from these processes are added to the hard copy Alert Sheet at the front of the Medical Record, and to WebPAS for online alert. |

| 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** |
| Although Healthscope is considering the introduction of an electronic record, at present all Healthscope hospitals remain using a paper based medical records system that includes both Healthscope and locally developed forms in accordance with Healthscope policy. WebPAS is integrated into the paper-based systems with forms printed out as required to the medical record. Records are overseen by the HGPH Health Information Manager and their team with support from state and national HIMs to ensure conformity with legislative and standards requirements.<br><br>All current medical records are available at the point of care. A system is in place to retrieve records from off-site storage in a timely manner, which can be as short as a few hours if the need arises.<br><br>Staff undergo regular education in the maintenance of accurate, complete and legible records in compliance with Healthscope Medical Records and related policies. In response to issues relating to the quality of documentation in recent years, HGPH has a Clinical Documentation Specialist who works with clinical staff to maintain standards. While the standard of nursing and allied health staff document is generally high, assessors noted deficiencies in Medical Officer documentation relating to completion of the paper-based National Standard Medication Chart, and a recommendation has been made under Action 4.01.<br><br>Healthscope has policies which guide staff to protect the IT security, privacy and confidentiality of patient clinical records, and policies relating to the release of confidential patient information. Healthscope has comprehensive, formal processes for development, review and document control of forms, documents and files that make up the paper healthcare record. Audits of the health record are tabled and discussed at the Clinical Governance Committee.<br><br>Assessors noted that all medical records complied with the various policy / jurisdictional requirements, forms were filed in a neat and orderly manner in a standardised format, and stored in such a manner that few if any records are permanently lost. This greatly assists in systemic audit of clinical information. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.17 |
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| 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** |
| HGPH meets the requirements of Advisory AS 18/11 as it relates to Actions 1.17 and 1.18 in accordance with the Healthscope approach to this Advisory. A gap analysis has been undertaken across all sites. Further work in implementing actions arising from the gap analysis is required by December 2022 and Healthscope is currently working towards implementing systems that can assist further data entry into the My Health Record (MyHR).<br><br>HGPH complies with the Healthscope Policy 2.66 My Health Record, with all Healthscope hospitals participating in the MyHR. HGPH uses standard national terminology. Data relating to nursing discharge summaries is currently regularly uploaded.<br><br>Further data will be uploaded when Healthscope introduces an EMR, although HGPH has no timeline regarding when this may occur. |

| 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** |
| Healthscope Policy 2.66 My Health Record describes the authorised access to MyHR and provides guidance for all Healthscope/HGPH employees, contractors and consultants about access to and use of the MyHR system. A system is in place at Healthscope to manage this complex process.<br><br>The designated person at HGPH is the General Manager (GM). An Action Plan is in place for the implementation of the MyHR system by December 2022.<br>Advisory 18/11 has been met as per Action 1.17. |

| 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** | |
| Healthscope has a comprehensive suite of policies that govern safety and quality for all members of the Healthscope team, including the governing body. Policies specify requirements for mandatory education and training commencing at orientation through to ongoing education for all employees, contractors, locums, agency staff, students and volunteers.<br><br>The responsibilities of VMOs related to safety and quality is via the Healthscope By-Laws. These are recorded in the C-Gov eCredentialling system. The By-Laws are scheduled for review in 2022 to enhance current requirements.<br><br>Position descriptions for HGPH managers and staff outline quality and safety responsibilities, with KPIs reported to Healthscope Corporate quarterly, and action plans in place for those not reaching KPI benchmarks. The mandatory training program was reviewed in 2018 resulting in the rationalisation of the volume of mandatory training requirements. | |
| **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** |
| The clinical education team at HGPH manage all aspects of the hospital's training needs. Included are mandatory training, orientation sessions for new staff, development of an education calendar and maintenance of Healthscope Learning, the online training platform for Healthscope staff. Much of the mandatory training is now online with all staff having access. The mandatory training program was recently reviewed, rationalised and streamlined.<br><br>Members of the workforce who may have difficulties with the English language, or who are not computer literate, are supported.<br><br>While online mandatory training rates are currently at an acceptable level, competency assessments have been compromised throughout the COVID-19 pandemic due to imposed limitations on non-essential staff attending the hospital. This has been recognised by the organisation and is being actively addressed. Nursing staff value their educational opportunities and feel well supported in this regard.<br><br>Responsibility for VMO education and training is governed through the Healthscope by-laws, and maintained in C-gov, the e-credentialling database. Agencies are contracted to ensure their staff have ongoing competency in BLS, emergency preparedness, manual handling and infection control, monitored through KPIs. Departmental orientation is also a requirement for agency and locum personnel.<br><br>Healthscope identifies the need for additional training items through the Shared Learning Report with these actioned by relevant hospitals. Quality and safety outcomes which do not meet benchmarks become a focus for targeted education, with improvements monitored through the quality improvement process at the Quality and Risk Committee.<br><br>A regular needs analysis is conducted to address non-mandatory training requests from clinical staff. |

| 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** |
| HGPH supports its staff to improve their cultural awareness and cultural competency in order to better meet the needs of Aboriginal and Torres Strait Islander patients. Mandated training in this regard commenced in 2019. Its mandatory training calendar has been adapted to now include ATSI Cultural Awareness training. Compliance monitoring is undertaken and compliance is quite high, although targets have been negatively affected by the Covid pandemic and plans are in place to improve.<br><br>To assist in its strategy to enhance cultural awareness, HGPH supports displays of Healthscope commissioned ATSI artwork and the display of the Healthscope Reconciliation Action Plan throughout the hospital, and an acknowledgement of Country is part of all HGPH meetings. Key events such as NAIDOC Week and National Reconciliation Week are promoted. The requirements of AS18/04 have been met. |

| 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** |
| HGPH has a structured and well-established performance review and development process, in accordance with Healthscope policy, for all employees. Policy states that a performance review is conducted at three months after commencement, and annually thereafter. Appraisal tools are inclusive of performance priorities (governance pillars), professional goals, educational training and development needs and monitoring of compliance with mandatory training. Identified training requirements are then incorporated into HGPH's training program. Interim appraisals are also conducted on the occasion of unsatisfactory performance and HGPH has access to the Healthscope Human Resources Department for performance issues if required. Additionally, reflective practice tools are used for nurses who make medication errors associated with failure to correctly follow policy. Assessors noted that all staff in the organisation they spoke with had undergone a performance review in the preceding 12 months. |

| 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** |
| Corporate policies are in place relating to credentialing and scope of practice with which HGPH must comply in order to demonstrate effective governance over defining the scope of practice of clinicians, including allied health staff and nurse practitioners. This is closely monitored through the KPI performance monitoring process.<br><br>VMO credentialling and scope of practice is captured in the online cGov system. This includes accreditation and re-accreditation with The Gastroenterology Society of Australia (GESA) for endoscopists. Information on credentialing and scope of practice is available to HGPH coordinators via WebPAS. Registration checking via the AHPRA registration checking system is conducted as part of onboarding practice and annually.<br><br>The position descriptions of staff denote scope of practice and are subject to review according to a review schedule. No nursing staff operate within an extended scope of practice at HGPH. Scope of practice is clearly defined in VMO letters of appointment.<br><br>The incident management system provides feedback on both VMO and staff performance with HGPH forums for clinical peer review being the Medical Advisory Committee and craft group meetings.<br><br>Clear processes are in place, through Healthscope policy, to guide the introduction of new clinical procedures and clinical technologies. A range of matters must be considered in any applications for new technology, including credentialling, scope of practice and training requirements. |

| 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** | |
| Healthscope has an online e-Credentialing Application and Management System which is fully implemented at HGPH. This is monitored by the HGPH General Manager. The HGPH credentialing audit compliance is sustained at 100%.<br><br>Although credentialling processes are thorough and well developed, all aspects are kept under review by Healthscope as a performance indicator for general managers. | |
| **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** | |
| HGPH has processes in place to ensure that its staff understand and perform their roles in safety and quality and assigns roles to them via their position descriptions. It was obvious to assessors that clinical staff understand their responsibilities in this regard, particularly in relation to accurate and comprehensive assessment and care planning. They take their role in minimising risks to patients seriously and understand both the importance of incident reporting and the need to implement quality improvement activities arising from incidents and near misses.<br><br>The role of clinicians in the provision of safe and high-quality care is emphasised during orientation and is further reinforced during mandatory training, particularly related to designated very high-risk areas. All training and education highlights safety and quality. The monitoring of system effectiveness through the audit process is increasingly understood.<br><br>Agency/locum workforce requirements are clearly articulated, including the undertaking that each person has the appropriate skills to provide safe patient care including an understanding of quality and safety systems in use at HGPH. This is achieved through contractual arrangements with the various agencies supplying clinical staff. | |
| **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** | |
| HGPH has systems in place which ensure clinicians can safely fulfil their designated roles, including after hours. Contracted medical staff cover 24 hour care onsite in the ICU and ED but are available for MET calls and emergencies throughout the organisation. FACEM support is available 24/7.<br><br>A member of the Executive is always on call to ensure that there is continuity of governance should a significant issue arise. Routine matters are delegated to the hospital coordinators.<br><br>HGPH has well developed formal supervision arrangements in place for Division 1 and 2 student nurses.<br><br>A range of specialist clinicians is readily available through VMO referral processes should the need arise. These include psychiatrists and infectious diseases physicians. | |
| **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 HGPH clinicians have access to a wide array of policies, protocols, guidelines, clinical pathways and decision-making tools on the intranet (HINT) or via the Healthscope librarian. Clinical pathways with variance analysis are available on HINT and clinical clusters/teams discuss relevant pathways and guidelines. Clinical guidelines are distributed to the HGPH MAC for discussion and quick access guides for key guidelines available via the HICMR website (infection control), to therapeutic guidelines and to various databases promoting evidence-based practice.<br><br>Assessors noted that HGPH has reviewed the Australian Commission on Safety and Quality in Health Clinical Care Standards and has conducted gap analyses and action plans for all relevant CCS, with several implemented.<br><br>Nationally standardised care pathways are in used in the Emergency Department e.g. STEMI, Asthma and Stroke and there is a recently introduced Sepsis pathway and a standardised process to manage anaphylaxis. | |
| **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** |
| HGPH is increasingly developing systems to monitor variation in practice against outcomes and providing feedback to clinicians. Benchmarking against external measures occurs where there are known sources. Healthscope through its centralised benchmarking program also offers excellent opportunities for peer review through outlier reporting.<br><br>The hospital submits ACHS indicator data and reviews its outcomes. Other mechanisms include contributions to specialist registries, Hand Hygiene Australia submissions, and Hospital Acquired Complications (HAC) monitoring.<br><br>The quality statements described in the Australian Commission on Safety and Quality in Health Care (ACSQHC) Colonoscopy Clinical Care Standard (CCS) have been incorporated into the management of the HGPH colonoscopy service. The Antimicrobial stewardship (AMS) CCS is also actively managed by the Cluster AMS Committee in line with requirements of the relevant Advisory from the Commission. Each time a new CCS is developed by the Commission, HGPH conducts a gap analysis and an action plan for application of the CCS. Assessors observed these plans and saw many examples of their incorporation, particularly in the Emergency Department.<br><br>Assessors were able to confirm that colonoscopists credentialled by HGPH are registered with the Gastroenterological Society of Australia (GESA) and collate and present relevant key performance indicator (KPI) data as part of their recredentialling. This is in accordance with requirements described in the ACSQHC Fact Sheet "Certification and recertification of practising adult colonoscopists".<br><br>Assessors agree that the requirements of ACSQHC Advisory AS18/12 "Implementing the Colonoscopy Clinical Care Standard", which relates to actions 1.23, 1.24, 1.27b 1.28a and b, are met.<br><br>As a private hospital, HGPH has other mechanisms to monitor variations in practice which may lead to unexpected outcomes and to provide feedback to clinicians via the MAC and craft group meetings.<br><br>Assessors were satisfied that HGPH would record its risks associated with poor outcomes of care in its risk register and mitigate accordingly. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.29 |
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| 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** |
| HGPH maximises safety and quality of care through monitoring its environment and maintaining its infrastructure at a high standard accordance with related Healthscope policies. As a newly developed facility, the hospital presented in a very neat and tidy condition with spacious, uncluttered corridors and external views for all patients. Infrastructure is well maintained as evidenced by maintenance logs and other documentation. Contractors are well managed to ensure safe, quality provision of service within a compliance framework.<br><br>Carparking is readily available and close by for both patients and staff, adding to safety.<br><br>It is obvious that thoughtful planning has taken place and that the needs of consumers for safety and comfort have been considered. The DOSA Unit is accessed from the entry foyer making it convenient for patients and their carers.<br><br>Patient rooms are mostly single with a small number of double rooms. Rooms close to nurses' stations are kept available for patients requiring close observation. Rooms are large, peaceful, well-appointed and welcoming.<br><br>Preventative maintenance and facility management, together with biomedical equipment servicing, are contracted to third parties and relationships appear to be effective. Reporting is robust.<br><br>The HGPH Disaster Plan is in place and well monitored, with all staff aware of their responsibilities in this regard. The hospital has an asset register monitored by the Finance Manager.<br><br>Throughout the facility are several empty shells which can be easily converted to new operating theatres and wards when anticipated growth is achieved in upcoming years. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.30 |
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| 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** |
| In reviewing incidents and policies assessors were able to confirm that HGPH is low risk in regard to patients presenting with serious unpredictable behaviours. However, it has systems in place to manage this occurrence. Higher risk areas have been identified through occupational violence and aggression audit and patient violence and aggression is a standing risk on the risk register. Staff are well educated in regard to emergency management in relation a Code Black. WAVE Workplace Aggression and Violence training is mandated for all staff. WAVE training includes de-escalation methods to reduce the risk of violence.<br><br>Strategies in place include night-time lockdown and the strategic placement of duress alarm buttons. Specific protocols are in place regarding management of high-risk patients, with specific alert processes on the medical record for patients known to be unpredictable. Care plans may be in place, developed in collaboration with the patient's family, to identify triggers and calming measures which may be of use when providing care. Policies and documentation are in place to guide transfer arrangements should the need arise for patients to be moved to more suitable facilities. Referrals to mental health professionals are well managed with access to psychiatrists and mental health nurse practitioners for support and advice.<br><br>Single rooms are available should a calm and quiet environment be beneficial to patient care. While not expressly for this purpose, a room in the ED can also be adapted as required. This is rarely used due to effective mechanisms in place to direct high risk patients to appropriate facilities before presentation to the hospital.<br>Education and training in the recognition and management of patients with delirium or cognitive impairment has assisted in improving outcomes for these patients, enabling clinical staff to monitor and respond effectively to agitation and/or delirium and/or behaviours of concern and to guide management of a patient's behaviour. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 1.31 |
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| The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose |
| **Comments** |
| Signage at HGPH is clearly visible, illuminated external to the building. Internal signage is plentiful and way finding was easy for assessors as walls and corridors are clear of clutter and extraneous material. Currently entrances are controlled at key points for COVID-19 purposes. Staff performing the check in process were helpful in guiding patients through the entry process and in directing them to where they needed to go, as visitors are currently still significantly restricted. More commentary is provided in this regard in Standard 3.<br><br>Ambulance bay parking is identified and clearly designated.<br><br>Fire safety maps and evacuation signage assist in egress from the buildings. |

| 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** |
| HGPH complies with Healthscope Policy 2.06 Visitors and Healthscope policy 0.01 Code of Conduct in regard to visiting hours. In response to frequent changing of visitor restrictions due to COVID, the hospital has continued to inform the public whenever a change has occurred and reviews requests on an individual basis. Flexible visiting arrangements are identified on the website.<br><br>Conversations with staff indicate that a flexible and compassionate response to visitor requests is currently in place. |

| 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** | |
| HGPH acknowledges the traditional owners of the land on which the hospital is built, conducting formal acknowledgement at the start of meetings and formal occasions. Staff are appropriately trained in cultural competence and provide a welcoming environment to all patients.<br><br>The Aboriginal Liaison Officer has established contacts within the City of Kingston and engages with their Aboriginal Liaison Staff as required. Local Aboriginal artwork is on display throughout the facility.<br><br>The Aboriginal and Torres Strait Islander flags are on display. HGPH acknowledges both NAIDOC and National Reconciliation Week with a range of culturally sensitive activities. | |
| **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** | |
| The Healthscope National Consumer Council provides a governance and reporting framework for all Healthscope hospitals and supports sites to participate in national meetings that oversee and monitor consumer participation. Covid has impacted on HGPH's volunteers and consumer participation over recent years and the executive team has instigated a renewal process to bring volunteers and consumer representatives on board. One of the new consumer representatives has attended a national meeting and received orientation and training for the role. | |
| **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** | |
| HGPH is renewing its consumer participant cohort now that the Covid pandemic is settling down. Consumers participate on the quality committee which oversees clinical outcomes, clinical incidents, consumer feedback and KPIs. The NPS score reflects high levels of consumer satisfaction. | |
| **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 Rights16 b. Easily accessible for patients, carers, families and consumers | |
| **Comments** | |
| The charter of rights is included in the patient compendium received on admission and is provided to patients on admission to DOSA. | |
| **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** | |
| Informed consent is audited and HGPH has identified the need for improvement in documentation of patient blood consent, including the reason for blood transfusion. The MAC reminded VMOs in a recent newsletter that there is room for improvement in documentation for blood consent. | |
| **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** | |
| During Covid, HGPH organised one or two key people to support cognitively impaired patients despite restricted visiting. Policies and processes are in place for substitute decision making if patients lack capacity. | |
| **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 assessors observed many patients' bedside handovers and some patient journeys from admission through theatres, and saw evidence at HGPH of the clinicians' commitment to shared decision making and partnering with consumers, including patients who were cognitively impaired and young paediatric patients. | |
| **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** | |
| The Assessors saw evidence of policies and procedures supporting the workforce to partner with patients and carers in shared decision making. The communication boards in the patient rooms were a focus of bedside handovers and inclusive of patients in the updating process. The assessors observed a commitment to a respectful and inclusive culture involving patients in their own care. | |
| **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** | |
| HGPH caters to diverse needs reflective of the local community, providing translation services as required predominantly for Greek, Italian, Chinese and Russian patients. Aboriginal and Torres Strait Islander needs are covered under the specifically related actions. | |
| **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** | |
| A number of consumers provide input to patient information and the multiple brochures developed for patients reflected this with the consumer tick. | |
| **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 Assessors observed clinicians providing appropriate information to patients along the patient journeys, including patient rights and responsibilities, falls and pressure injury prevention, nutrition, infection control for specific issues including Covid prevention, and Hand Hygiene. The brochures were plain and simple, all of which had been consumer checked for clarity. There was readily available information on the call and respond system if patients had concerns. | |
| **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** | |
| Consumers were reported to be involved in the development and design of HGPH in the transition from Como private hospital. The executive reported plans for further consumer involvement in the expansion of the facility and the strategic planning process, including projects emerging from the plan. | |
| **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** | |
| HGPH's recently appointed consumer representative reported an extensive orientation and support processes including involvement in the overseeing of organisational measurement and evaluation information tabled at the national and local level. | |
| **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** | |
| HGPH complies with the identification, acknowledgement and cultural safety commitments required for Aboriginal and Torres Strait Islander communities. Brochures are available providing information. There were 120 patients identifying in 2021, however it was noted that a number of patients did not identify at all. HGPH is conducting a review of the non-identifying patients to clarify if there is an issue. Discharge planning and referrals are supported through collaboration with the Kingston Council Aboriginal Liaison Officer to support patients during admission and on discharge. | |
| **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** | |
| Education and training in relation to partnering with consumers is supported at a national and local level and there are plans for expansion at the local level once additional consumers have been recruited. | |
| **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** |
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| 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** |
| The HGPH infection prevention and management framework is incorporated within and governed by the Healthscope national framework. HICMR is the expert external Infection Prevention and Control (IPC) agency that is contracted by Healthscope to ensure all Healthscope sites comply with the IPC standards requirements. There is a comprehensive suite of Healthscope evidence-based policies to guide practice. These policies are updated and monitored through regular audit and surveillance processes. The governing body monitors IPC outcomes across all its hospitals. HGPH contributes data to the dashboard for benchmarking against other Healthscope sites, and HGPH has a good record with minimal hospital acquired infections.<br><br>HGPH is part of an effective Healthscope Webex IPC team which monitors all infection control activities across the group including infection rates. This IPC cluster reviews related incidents, ACHS clinical indicators and guides the implementation of policies and procedures at each site, including HGPH local Infection Prevention and Control Committee (IPCC). Risk management in infection control is robust at HGPH. All infection control related risks on the hospital's risk register are regularly reviewed and action plans implemented, including the Covid outbreak HGPH management plan developed in collaboration with HICMR.<br><br>The antimicrobial stewardship program implementation is a priority for HGPH following audits showing low VMO compliance with prescribing guidelines. The nursing staff, supported by the Medical Advisory Committee (MAC), have instituted a system to ensures there is a "stop and review - red/amber/green (RAG)" process to identify when prescribing orders are non-compliant with the guidelines. Nurses have been authorised to raise questions as appropriate. Mandatory training for prevention and management of infections is in place. This program includes Hand Hygiene and ANTT (copyright to HICMR). During Covid, the ANTT learning modules have continued whilst observational audits have proven difficult. There is a 2022 plan for the wards to identify ANTT procedure competencies for each staff member and to undertake observation audits.<br><br>HINT provides Healthscope Library materials for effective infection control including Australian Guidelines, the Australian Hand Hygiene Initiative; HICMR Policy and Procedure Manual, and audit tools. HGPH also met the requirements of the National Standard Preventing and Controlling Infections 2021 as set out in Advisory AS 21/01 through implementation of its action plan. |

| **Rating** | **Applicable HSF IDs** |
|---|---|
| Met | All |

| ACTION 3.02 |
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| 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** |
| HGPH has quality improvement systems in place to monitor the performance of its infection prevention and management program, including the audit program monitoring compliance with the IPC standard and surveillance systems locally adapted to case mix. Infection surveillance data is reported both internally to Healthscope and to VICNISS for benchmarking against peer hospitals. Data is provided to Hand Hygiene Australia.<br><br>HICMR have undertaken a gap analysis against the IPC standard with HGPH and supported the implementation of an IPC action plan. The plan is annually reviewed including staff health, the surveillance framework and a risk management plan.<br><br>Incidents relating to infection control are entered into the organisation's RiskMan database from where they are analysed. The records indicate that incidents and infection rates are minimal.<br><br>The effectiveness of the antimicrobial stewardship (AMS) program is monitored by an AMS committee and HGPH have implemented improvement strategies to address to low compliance with prescribing documentation in alignment with the guidelines. The strategy includes a "stop and review" system to prevent inappropriate prescribing. The Medical Advisory Committee (MAC) provides support to implementation of improvement strategies including those for AMS and compliance with ANTT mandatory observation audits for all staff including VMOs.<br><br>The management of COVID-19 has been a priority over recent times and the Assessors observed evidence of appropriate compliance with Department of Health IPC guidelines. The introduction of the sepsis pathway has been a priority supported by the MAC.<br><br>HGPH's Clinical Governance Committee overseen by Healthscope monitors all of the IPC outcomes and improvement strategies. Outcomes are also displayed for staff, patients and visitors on Quality Boards in each ward/department. Related issues are discussed at regular ward/departmental meetings, and at the MAC. Results are also exhibited on the My Healthscope website – HGPH.<br><br>HGPH has implemented additional training to prevent and manage the Covid 19 infection and ensured staff are appropriately fit tested with PPE. The nursing staff have put systems in place to alert VMOs if they prescribe outside the AMS guidelines and to ensure the sepsis pathway is implemented. The nurses are supported by MAC and the chair ensures VMOs are advised of expectations in the regular MAC newsletter to keep them updated on the requirements of the National Standards. |

| 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 |
| The Medical Advisory Committee (MAC) provides support to implementation of improvement strategies including those for AMS and compliance with ANTT mandatory observation audits for all staff including VMOs.<br><br>The management of COVID-19 has been a priority over recent times and the Assessors observed evidence of appropriate compliance with Department of Health IPC guidelines. The introduction of the sepsis pathway has been a priority supported by the MAC.<br><br>HGPH's Clinical Governance Committee overseen by Healthscope monitors all of the IPC outcomes and improvement strategies. Outcomes are also displayed for staff, patients and visitors on Quality Boards in each ward/department. Related issues are discussed at regular ward/departmental meetings, and at the MAC. Results are also exhibited on the My Healthscope website – HGPH.<br><br>HGPH has implemented additional training to prevent and manage the Covid 19 infection and ensured staff are appropriately fit tested with PPE. The nursing staff have put systems in place to alert VMOs if they prescribe outside the AMS guidelines and to ensure the sepsis pathway is implemented. The nurses are supported by MAC and the chair ensures VMOs are advised of expectations in the regular MAC newsletter to keep them updated on the requirements of the National Standards. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.03 |
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| 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** |
| HGPH has quality improvement systems in place to monitor the performance of its infection prevention and management program including the audit program monitoring compliance with the IPC standard and surveillance systems locally adapted to casemix. Infection surveillance data is reported both internally to HSP and to VICNISS for benchmarking against peer hospitals. Data is provided to Hand Hygiene Australia.<br><br>HICMR have undertaken a gap analysis against the IPC standard with HGPH and supported the implementation of an IPC action plan. The plan is annually reviewed including staff health, the surveillance framework and a risk management plan. Incidents relating to infection control are entered into the organisation's RiskMan database from where they are analysed. The records indicate that incidents and infection rates are minimal.<br><br>The effectiveness of the antimicrobial stewardship (AMS) program is monitored by an AMS committee and HGPH have implemented improvement strategies to address to low compliance with prescribing documentation in alignment with the guidelines. The strategy includes a "stop and review" system to prevent inappropriate prescribing.<br><br>The Medical Advisory Committee (MAC) provides support to implementation of improvement strategies including those for AMS and compliance with ANTT mandatory observation audits for all staff including VMOs.<br><br>The management of Covid 19 has been a priority over recent times and the Assessors observed evidence of appropriate compliance with IPC guidelines.<br><br>The introduction of the sepsis pathway has been a priority supported by the MAC. HGPH's Clinical Governance Committee overseen by HSP monitors all the IPC outcomes and improvement strategies. Outcomes are also displayed for staff, patients and visitors on Quality Boards in each ward/department. Related issues are discussed at regular ward/departmental meetings, and at the MAC. Results are also exhibited on the My Healthscope website – HGPH |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.04 | |
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| 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** | |
| The Assessors attended bedside clinical handovers and were able to observe how clinicians actively partner with patients to involve them in their own care, meet their information needs and share decision making regarding infection prevention and control.<br><br>Patient information brochures are available regarding infection prevention and control. Some brochures outline general infection control principles and others are specific to an identified risk.<br><br>Resources are provided by HICMR to ensure HGPH has the capacity to monitor compliance with the standard including the effectiveness of the AMS program. There is an expectation that compliance with AMS will improve following the improvement strategies implemented by nursing staff to "stop and review" non-compliance with the guidelines. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 3.05 |
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| 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** |
| In Victorian hospitals, surveillance of healthcare associated infections (HAI) is mandated through the Victorian Healthcare Associated Infection Surveillance System, known as VICNISS. Accordingly, HGPH contributes data through its audit program. The surveillance program at HGPH extends beyond that required by VICNISS, and includes hand hygiene, exposures to blood and body fluids, and staff immunisation. Antibiotic monitoring also forms part of the surveillance process and most recently specific COVID-19 initiatives have also been included in surveillance measures.<br><br>In regard to antimicrobial stewardship, HGPH submits data annually to the National Antimicrobial Prescribing Survey (NAPS).<br><br>Surveillance is conducted via the HICMR surveillance toolkit which provides a standardised approach and facilitates benchmarking across Healthscope hospitals. Indicators collected include Staphylococcus aureus bloodstream infections, surgical site infections and influenza vaccination rates. Most recently Covid vaccination rates have been included. Assessors reviewed audit results relating to the surveillance program and noted negligible infection rates, consistently high vaccination rates and strategies being implemented to improve antimicrobial prescribing, from a low base. There are processes and systems in place to review individual cases when an infection is identified.<br><br>HGPH's surveillance data informs strategies to reduce risks associated with HAI as identified through HICMR policies. All surveillance outcomes are reported to staff, consumers and via the HGPH clinical governance structure (including initially the HGPH and Healthscope Infection Prevention and Control Committees) through to Healthscope and its Board. Results are tabled at the MAC meeting and relevant craft groups. Safety and quality boards display related information throughout the hospital. Selected surveillance information is also presented on the MyHealthscope website, including rates of Staphylococcus Aureus bacteraemia, MRSA, MSSA and hand hygiene. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.06 |
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| 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 Healthcare17, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws |
| **Comments** |
| HGPH has processes in place to apply standard precautions and transmission-based precautions in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.<br><br>HICMR policies define and describe standard and transmission-based precautions and are readily available to staff in HINT, including the availability of a Transmission-based precautions Toolkit. HICMR also provides a 24-hour consultancy service should nursing staff have any questions. New infections are reviewed daily and both the HICMR consultant and the IPC Consultant are available to assist staff in the application of relevant precautions as a result. Assistance is also provided to environmental and food services staff.<br><br>All patients admitted have standard precautions implemented. Patients arriving at Emergency Department are screened for Covid before entering the department. Pre-admission telephone screening is in place for DOSA patients who are screened again on arrival.<br><br>The HGPH IPC coordinator supported by HICMR ensures that COVID-19 appropriate screening, precautions and patient placement are in place. Signage is used for transmission-based precautions. Terminal cleaning requirements are clearly documented. An alert is entered onto the Alert Sheet at the front of the Medical Record and on WebPAS so that all staff are aware. Compliance with policy is monitored including donning and doffing of protective personal equipment (PPE). |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.07 |
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| 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** |
| Clinicians assess infection risks and use risk-based transmission precautions as required in accordance with related HICMR policies. Assessment of infection risks is a key element at all entry points to the organisation, whether it be for elective pre-admission, non-elective admission or via the Emergency Department. Visitor access (restricted during Covid) and outpatient access is monitored and appropriate transmission precautions implemented. Specific assessment for COVID-19 risks is included.<br><br>Factors such as environmental controls, transportation within the facility, cleaning procedures, and equipment requirements are taken into consideration.<br><br>Whilst HGPH is not Covid streaming hospital, a small number of vulnerable patients found to test positive with Covid have remained at HGPH and been cared for with appropriate isolation transmission precautions.<br><br>Appropriate personal protective equipment (PPE) is available, and staff are fit tested for best protection with N95 masks as a minimum requirement in all clinical areas. Safety goggles are worn in clinical areas. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.08 |
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| 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** |
| Processes are in place for communicating a patient's infectious status on referral, on admission and on transfer of care. The IPC coordinator or the HICMR consultant reviews new infections on a daily basis from microbiology reports, setting in place the requirements for appropriate placement, isolation and patient care.<br><br>Elective patients complete a pre-admission screening tool which includes a section regarding their infectious status. Sometimes a doctor will inform the hospital of this. The screening tool is reviewed on the day of admission.<br><br>On confirmation of infectious status, an Alert is triggered on the Alert form at the front of the medical record, and in the WebPAS electronic alert system. This alert guides the response for appropriate precautions and patient placement.<br><br>Personal Protective Equipment (PPE) is readily available if precautions need to be in place. Infectious and terminal cleaning requirements were clearly documented, and audits are undertaken to ensure compliance.<br><br>Environmental audits are undertaken to ensure appropriate cleaning compliance. Equipment disinfection occurs in accordance with HICMR policies and manufacturers' instructions.<br><br>All results are discussed at the HGPH and Healthscope Infection Control Committee meetings, and related performance indicators are reported to Healthscope and the Board via internal communications processes. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.09 |
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| 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** |
| Review of data on community infections is incorporated into the HGPH Covid response and the rise in infections in schools on the students returning currently is impacting on the workforce with staff caring for Covid positive children at home leading to a depletion in staffing. Reallocation of education and other qualified staff to clinical areas has been supported by staff during this time. On confirmation of infectious status, an Alert is triggered on the Alert form at the front of the medical record, and in the WebPAS electronic alert system. This alert guides the response for appropriate precautions and patient placement. This information is transferred with the patient. Patients are given information on infection prevention, COVID-19 and other specific infectious disease information. The Assessors observed patient bedside handovers and it was clear that infectious information would be included and discussed with the patient as appropriate. |

| Rating | Applicable HSF IDs |
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| ACTION 3.10 |
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| 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** |
| At HGPH hand hygiene (HH) is monitored as per the Hand Hygiene Australia program. and audits are completed as per the audit schedule by trained auditors and in accordance with Healthscope policy which states that hand hygiene training is mandatory for all staff. Like many health services, HGPH has continued HH audits during the pandemic. Audits are conducted by moment and healthcare worker designation and audit reports across the organisation indicate compliance of 86-88% over the last three periods. Hand Hygiene messaging was obvious throughout the hospital. Alcohol-based hand rub is readily available, with HH stations extensive and clearly located throughout the hospital. Assessors observed that hand hygiene is consistently performed by staff, patients and visitors. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.11 | |
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| 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** | |
| HICMR has contractual access to the ANTT copyright information and learning modules. There is compliance with ANTT eLearning modules monitored by the IPC committees for HGPH and Healthscope. The nurse IPC coordinator and DON are working with nurse managers to identify the skill matrix for unit clinical staff to ensure observational ANTT competency audits are conducted on all relevant staff in alignment to the procedures they are approved to undertake. Competency assessments have been hampered during Covid and there is a quality improvement focus on this area. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 3.12 | |
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| 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 Healthcare17 | |
| **Comments** | |
| Assessors noted that invasive devices are well managed and appropriately used in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare at HGPH.<br><br>Supporting Healthscope and HICMR policies are comprehensive and easy to access. No incidents regarding the use of invasive devices have been identified. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 3.13 |
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| 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 Healthcare17 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** |
| Environmental cleaning practices at HGPH are of a high standard in compliance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare, which have been risk assessed and incorporated into relevant HICMR policies and procedures covering environmental services, food services, maintenance, management of clinical waste, and linen. Each policy conforms with jurisdictional requirements, legislation and Australian Standards. Each element is closely monitored to ensure compliance and results are reported regularly to the IPCC.<br><br>Regular cleaning audits are undertaken across the organisation. Action plans are developed and monitored if variances occur. Cleaning schedules include frequencies and are responsive to emerging/changing environmental risks including Covid.<br><br>Environmental Services staff are trained in infection control. All staff have relevant vaccinations in accordance with organisational policy.<br><br>HICMR policies and the Transmissible Diseases Toolkit govern outbreak control e.g. Gastroenteritis.<br><br>All staff who provide care in the clinical setting are appropriately trained in the use of personal protective equipment, including donning and doffing. All relevant staff have been fit tested for high filtration masks. Face shields or safety glasses are worn in clinical areas in compliance with policy. Audits confirm effective infection control through this mechanism with negligible transmission rates between patients and staff. |

| Rating | Applicable HSF IDs |
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| Met | All |

| ACTION 3.14 |
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| 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** |
| Processes are in place to evaluate and respond to infection risks for new and existing equipment, devices and products used in the organisation. The Infection Control Coordinator and HICMR consultant ensure compliance with manufacturers' guidelines for equipment.<br><br>Assessors noted that the hospital was clean and well maintained. The kitchen, whilst small, was very clean and functional, with staff committed to good IPC practices. Food services audits demonstrate a safe environment for food handling.<br><br>Segregation, storage and disposal of all waste meets standards and environmentally friendly systems are used whenever possible.<br><br>Building maintenance and repair, including equipment, furnishings and fittings, are maintained in house and coordinated with contractors as required.<br>Linen cupboards and systems were well maintained. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 3.15 |
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| 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 Handbook19 b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients |
| **Comments** |
| A risk-based workforce immunisation program which is consistent with the current edition of the Australian Immunisation Handbook and with jurisdictional requirements for vaccine-preventable diseases is in place at HGPH, in accordance with the Healthscope Policy – Immunisation for Vaccine preventable diseases – Staff, and HICMR policy Staff Health.<br><br>All new staff must be fully compliant with the requirements of the policy before commencement. Data related to immunisation at HGPH is provided for KPI monitoring purposes. Full COVID-19 vaccination for staff is a national requirement and HGPH staff are compliant. |

| 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 Handbook19 b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients | |
| Vaccination against seasonal influenza is a priority for HGPH this year with room for improvement on previous rates. Blood and body fluid exposures are monitored by HICMR and managed in accordance with Staff Health policy. Vaccination status is reported to VICNISS and monitored by the IPCC. | |
| **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 Healthcare17 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** | |
| Risk based processes consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare are in place for managing infections in the workforce. HGPH aligns to the Victorian DoH public health jurisdictional guidelines. This included participation in the state-wide code brown Covid response which has now been stood down. HGPH has a Covid management plan to control risks to the workforce, patients and consumers. Consumer and volunteer participation has been limited during Covid and there is a new focus to refresh the consumer participation and reporting systems and structures locally. Staff are given leave to isolate as required following exposures to or acquisition of infection(s). The workforce has been impacted by the return to schools resulting in increased Covid positive children requiring isolation and care at home. HICMR supports HGPH and Healthscope in managing ongoing service provision during the outbreaks. HGPH adjusts admissions according to staffing capacity and resources as part of the Covid plan. | |
| **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** | |
| Assessors observed that processes for reprocessing consistent with AS/NZS 4187:2014, in conjunction with manufacturers' guidelines, were compliant with the standards at HGPH. Reprocessing of reusable devices occurs in the CSSD, operating under the HICMR Sterilising Services Manual which reflects relevant national and international standards. HGPH is compliant with AS 18/07: Reprocessing of reusable medical devices in health service organisations.<br><br>The computerised tracking and traceability procedures are rigorous, and the assessors observed this in CSSD.<br><br>Integrity of sterilisation is monitored, and regular microbiological testing occurs in the endoscope cleaning room. Assessors observed cleaning, disinfecting and sterilising of reusable devices and confirmed that the requirements of the policies and procedures to support the process were met. | |
| **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 Healthscope Policy Antimicrobial Prescribing and Management, the HICMR Policy and Procedure: Antimicrobial Stewardship (AMS) and the Healthscope Pharmacy Services (HPS) Antibiotic Stewardship governs the use of antimicrobials at HGPH, overseen on its behalf by the AMS Committee reporting to the IPCC.<br><br>Healthscope promotes evidence-based practice in line with the Australian Therapeutic Guidelines. The auditing program aligns with the current National Standards. The compliance with the Antimicrobial Stewardship (AMS) clinical care standard and prescribing guidelines needs improvement at HGPH. The MAC has supported the DON and nurse managers' implementation of a "stop and review" alert and colour coding system which is reported to be working well. It is expected that the next audit will show improvements. |
| **Suggestion(s) for Improvement** |
| That HGPH continues to implement the AMS prescribing improvement program of "stop and review" alert and colour coding. That HGPH undertakes a re-audit to evaluate the impact of this improvement process and system. |

| 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** |
| Assessors noted that the MAC and nurse management are committed to the antimicrobial stewardship program at HGPH with the "stop and review" alert and colour coding system. Outcomes of AMS audits are reported to the IPCC and through the clinical governance structure to the Healthscope Executive and Board. It is expected that the next prescribing audit and evaluation of the "stop and review" program should reflect increased compliance with the prescribing guidelines for appropriateness and duration as well as surgical perioperative prophylaxis duration / cessation times that are currently not well documented.<br><br>The AMS Committee reviews all antibiotics prescribed in the organisation and feeds back to individual clinicians whenever antibiotic prescribing is less than optimal. HGPH participates in the National Antimicrobial Prescribing Survey (NAPS) and the National Antimicrobial Utilisation Surveillance Program (NAUSP), producing reports that were made available to assessors. This data, together with VICNISS audits, is routinely reported to clinicians through the MAC. |

| 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** | |
| Medication safety is generally well managed with good governance which includes a comprehensive suite of policies and procedures, most of which are centrally developed through Healthscope. A national medication management cluster provides comprehensive support. At HGPH, medication management is overseen by the multidisciplinary Medication Safety Committee and reports to the Quality and Risk Committee for governance oversight.<br><br>As stated, governance of medication management is defined by a comprehensive suite of Healthscope policies and procedures, with a small number of procedures developed locally to meet local requirements. These apply a risk-based approach to effectively minimise incidents and harm.<br><br>Medication management risks are identified through incidents reported in RiskMan, and appropriate actions are taken. HPS Pharmacies, the third-party provider of pharmacy services to HGPH, also use an internal risk management program Paradigm, and provide reports back to the hospital. Assessors observed a local HPS pharmacy action plan for quality and safety purposes which supports and complements the hospital's endeavours.<br><br>Nurses undertake medication management training with 87% having completed the MedSafe package against a target of 92%. The training plan focuses on mandatory training modules. Additional education is carried out by the education team through a needs analysis process. | |
| **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** |
| HGPH applies appropriate quality improvement systems to strengthen effective medication management in the organisation. Monitoring occurs via its committee structure, through incident monitoring, and its structured audit program. Reports are provided through the governance structure to and from the Healthscope Patient Care Review Committee, HGPH Medication Safety Committee (reporting to the Quality and Risk Committee) and the Medical Advisory Committee (MAC). Incident reviews lead to the development of strategies to improve performance through monitored action plans.<br><br>Nursing staff feel well supported relating to information about medication incidents through staff meetings and documentation on safety and quality noticeboards throughout the organisation. Quality improvement initiatives are also displayed, including in public areas where patients and visitors can view it. Several examples of quality improvements were observed. These strategies are implemented to improve medication management outcomes and associated processes. An excellent initiative is the introduction of the coloured dot system, where coloured dots are applied to medication charts which have been checked for accuracy and completeness by two nursing staff.<br><br>Nursing staff who contribute to a medication error complete a reflection tool monitored by the nursing education team. Analysis indicates that these nurses rarely re-offend.<br><br>While examples were provided of fully compliant National Standard Medication Charts (NSMC), assessors noted instances of non-compliance on a range of parameters relating to some visiting medical officer (VMO) prescribing. These observations confirmed the organisation's audit findings over two years and demonstrated little traction over time despite repeated education. HGPH has recently developed a comprehensive plan to address this issue more actively with relevant VMOs, and this is an item for discussion on the next MAC meeting agenda. A recommendation has been made to implement and monitor this quality improvement plan. |

| Rating | Applicable HSF IDs | Recommendation(s) / Risk Rating |
|---|---|---|
| MWR | All | **Recommendation:**<br>The organisation implements the quality improvement action plan relating to VMO compliance in completing the National Standard Medication Chart in accordance with policy and legislation.<br>**Risk Rating:**<br>Moderate |

| 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.<br><br>Consumer engagement commences at pre-admission, when patients provide medication and adverse drug reaction information, which is then followed up. The patient information booklet provides instructions about medications. Patients interviewed indicated that medication management was discussed with them, 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** | |
| Scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians. Audits demonstrate satisfactory compliance. | |
| **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 possible medication history (BPMH), which is documented in the healthcare record on presentation or as early as possible in the episode of care, is taken by nursing staff, or a pharmacist (if warranted) in accordance with policy.<br><br>Assessors observed adequate history taking but noted that a pharmacist only takes the history in 10% of cases. While this may reflect current case mix, assessors suggest that HGPH benchmark this rate against peer hospitals to ensure sufficient pharmacy input occurs when needed.<br><br>Systems are in place for early referral to pharmacists for Medication Management Plans (MMPs). All elective patients provide a list of medications, which is confirmed by the admitting nurse. |

| 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** |
| Assessors confirmed that current medications are reconciled and reviewed for accuracy against the best possible medication history on presentation and at transition points throughout the patient journey through discussions with nursing staff and review of documentation.<br><br>Assessors observed that appropriate referral to the clinical pharmacist is undertaken in a timely manner. |

| 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 defined and monitored in accordance with Healthscope policy. Assessors reviewed records and observed nursing interactions to confirm this.<br><br>An audit tool has been developed to cover all charts on which an ADR is recorded. Audits demonstrate increasing compliance with the numerous areas in the patient record where ADRs must be recorded to ensure all relevant staff are aware. | |
| **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 reporting culture. Medication related incidents are reviewed by the Medication Safety Committee.<br><br>Pharmacy staff assist in the process. | |
| **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 through its relationship with Healthscope pharmacy services. | |
| **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** | |
| Medication reviews in line with evidence and best practice using the Medication Management Plan (MMP) Risk Assessment form are prioritised based on the patient's clinical needs to minimise the risk of medication-related problems. Patients who are prescribed antibiotics are reviewed as part of the antimicrobial stewardship program by a pharmacist.<br><br>Nursing staff and pharmacists were able to describe this process of medication review, how it is documented and how actions taken in response to the review are followed though. | |
| **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 having received the Healthscope consumer tick where appropriate. Staff have access to consumer medicines information (CMI) from eMIMS, a pharmacist is available to discuss newly prescribed medications, and counselling is provided on discharge.<br><br>Patients reported being able to understand the 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** | |
| Assessors confirmed that a list of current medications is provided whenever a patient is discharged or transferred. This list makes specific reference to the taking of high-risk medications. General practitioners receive this information as part of the discharge summary process.<br><br>Current medicines are reviewed at clinical handover as part of a three-way conversation between shift changing nursing staff and the patient. Assessors saw examples of this in practice. | |
| **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** | |
| Doctors and nurses have easy access to extensive information and medication management decision support tools via the Healthscope intranet (HINT) and expressed no concerns with this system.<br><br>Hardcopy versions of references were all observed to be up to date. | |
| **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.<br><br>Assessors observed that all medication rooms were locked with controlled swipe card access, and the S8 safes in the wards appropriately managed in accordance with jurisdictional requirements. Completed drug books are subject to strict systems of control in regard to transport and storage.<br><br>Patients' own S8 and S11 medications are sealed in tamper resistant bags and stored in the safe in the pharmacy.<br><br>Rigid hard walled containers are used for the transport of cytotoxic medications.<br><br>Storage and management of temperature-sensitive medicines and cold chain management is well monitored with central alarm systems in place. Appropriate disposal is available for unused, unwanted and expired medications from the wards and the pharmacy. | |
| **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** |
| High risk medications are well managed. Nurses were aware of the APINCH acronym and were able to identify associated risks. Assessors observed that high risk medications are clearly identified in medication rooms and tall man lettering is in place with additional identification measures also in place.<br><br>While potassium chloride ampoules have been replaced with 10mmol/100mL IV bags in all areas except CCC and theatre, assessors noted several boxes of 1000ml bags of fluid containing premixed KCL which are occasionally used in the ward area. Assessors suggest that this practice be reviewed.<br><br>Assessors observed that signature registers are well maintained and that S8 and S11 registers include page numbers and their archiving is controlled. Assessors found that IV line labelling was well done.<br><br>The VTE Prevention Clinical Care Standard gap analysis has been completed and assessors observed compliance in completing this section on the medication chart for those charts audited by assessors during the assessment. |
| **Suggestion(s) for Improvement** |
| Review the need for 1000ml flasks of fluid with KCL additive to be kept in the wards. |

| 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** |
| HGPH has an array of policies to guide staff members in the provision of comprehensive care across its range of clinical services. Most of the policies are Healthscope wide, with only a small number being HGPH specific. A policy statement section is included in each policy clearly outlining the key elements of the policy. Approved policies are readily accessible to staff members via the Healthscope intranet, HINT. Overarching guidance for the provision of comprehensive care is provided by the Healthscope Comprehensive Care Plan Policy and the Comprehensive Risk Screening Tool Policy. HGPH has a well-established risk management monitoring system, both at the corporate level and within HGPH. HGPH also has an audit schedule in place covering several aspects of comprehensive care.<br><br>HGPH has a strong focus on training and ongoing education which commences at orientation and induction. This includes through online training modules and training that is relevant to the comprehensive care standard. The training program covers, for example, falls, pressure injury and malnutrition assessment. There has been training related to the completion of the comprehensive risk screening form. There has also been considerable training focussing on the management of delirium and behaviours of concern and the prevention self-harm and suicide. In addition, the Dietitian has provided training focussing on embedding the use of the Malnutrition Screening Tool (MST) and in the management of nutrition and hydration. Staff training was also provided in relation to the Back to Bedside and the Back to Basic initiatives.<br><br>Assessors acknowledge the efforts of the HGPH education team in implementing the Training into Critical Care (TICC) program. This program has enabled the upskilling of several HGPH nurses. The HGPH training and education program is very well managed by the Education team and is monitored through the clinical governance committee structure.<br><br>Assessors noted that Healthscope has established a series of Webex online clinical special interest groups which enable an exchange of ideas amongst clinicians and supports the provision of evidence-based patient-centred care. There are Webex teams, for example, related to behaviour and cognition, falls, diabetes and clinical deterioration. |

| **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** |
| The HGPH Comprehensive Care Committee meets quarterly and provides governance oversight to the various elements of the comprehensive care standard. Membership of the committee includes key senior clinical staff from across the range of HGPH clinical areas. The Comprehensive Care Committee reports through the HGPH clinical governance system, in particular to the HGPH Patient Care Review Committee. The Comprehensive Care Committee also has close links with the Medical Advisory Committee. HGPH working parties to support the Comprehensive Care committee are in place. These consist of the VTE/Pressure/Nutrition Working Party, the Falls/Mental Health and Cognitive Impairment Working Party, the Paediatric Working Party and the End-of-Life Working Party. Assessors noted that Comprehensive Care Committee agendas and minutes are thorough. A person or group (such as the Education Team) is allocated responsibility for undertaking actions and this is recorded in the minutes. Progress is monitored at each committee meeting.<br><br>The Comprehensive Care Committee monitors Quality KPI (Key Performance Indicator) reports, ACHS Clinical Indicator data, mandatory training reports, clinical incident reviews, policy changes, hospital acquired complications, audit results, quality improvement activities and relevant risks. Reports from the comprehensive care working parties and Healthscope-wide shared learnings are also reviewed. In addition, the committee monitors and reviews any episodes of restrictive practices or “specialling” that may occur.<br><br>Information flow to and from the Visiting Medical Officers (VMOs) is through the Medical Advisory Committee and specialist craft groups, although many informal information channels are also in place. Comprehensive care related matters are also reported to nursing staff through ward clinical meetings and via staff emails. Key audit results and staff training levels are also displayed on ward quality boards.<br><br>Assessors noted that HGPH has undertaken several quality improvement initiatives related to the provision of comprehensive care across its clinical areas. Examples include projects to improve fluid balance monitoring, to improve drain tube management and to introduce observation chart documentation prompt cards. Posters outlining the HGPH stomal therapy pathway, skin tear assessment and management and pressure injury management and prevention have also been developed. The introduction of the Clinical Risk and Documentation Improvement Co-ordinator position has been well received by ward nursing staff. The Coordinator provides daily on-the-spot support to the ward nurses regarding all aspects of the provision of comprehensive care, including each of the specific risks listed in the standard.<br><br>Assessors noted that clinical incident rates related to falls with significant injury and pressure injury have been trending downwards and compare favourably with other organisations. HGPH attribute this to a number of factors. This includes ongoing staff training, excellent support ward staff receive from the HGPH Clinical Nurse Consultant – Wound Care team and the Clinical Risk and Documentation Improvement Co-ordinator, and the ready availability of high quality aids and appliances. It was also felt that the Back to Basics and Back to Bedside initiatives have strengthened processes related to the delivery of patient-centred care. In addition, there has been an increased focus on early pressure injury screening and assessment in the Emergency Department. |

| 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 | |
| HGPH has undertaken a considerable amount work in the development of gap analyses and action plans related to the Comprehensive Care Standard ASQHC Advisories. Progress has been substantial and is clearly documented. | |
| **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** | |
| The Healthscope Consumers - Partnering with Policy provides advice to clinicians in a range of matters related to the provision of patient-centred care. Various policies and procedures covering the range of clinical services provided by HGPH also emphasise shared decision making and goal setting. This includes the outpatient programs provided by allied health clinicians. Care planning forms are designed to facilitate the documentation of shared decision making and the ongoing consideration of patient goals. HGPH has well established processes to engage with its patients during their care. This includes through admission assessments, ward rounds, patient rounding, the use of patient care boards and where relevant, family meetings. Various multidisciplinary craft group team meetings, case conferences and huddles are also regularly held. Assessors observed well conducted bedside handovers which included good engagement and communication with the patients.<br><br>Assessors noted the HGPH Back to Bedside and Back to Basics initiatives included several elements that support patient-centred care. The use of ward patient care boards which display a range of relevant information and regular patient rounding are two examples. The provision of verbal and written information to patients to support their involvement in decision making often commences prior to admission, in particular for elective surgical patients. A wide range of information brochures are available to patients and their families. Many of the brochures are Healthscope-wide publications and include the Consumer Approved Publication logo.<br><br>Qualtrics patient experience data along with verbal feedback provided by patients to Assessors indicate that HGPH patients have a high level of satisfaction with their overall care, the amount of information they receive and their involvement in decision making. | |
| **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** |
| HGPH currently uses a paper-based health care record. A variety of well-designed Healthscope forms are used by HGPH clinicians to document all aspects of patient care across its range of clinical services. Whilst some forms are generic and used across several wards, others are tailored to meet the needs of specific speciality clinical areas, such as Intensive Care, Coronary Care, Theatre and the Emergency Department.<br><br>WebPAS is used in the clinical areas to access medical imaging and pathology results, to make internal referrals, to record alerts, to generate ward clinical handover sheets and to facilitate nursing and Emergency Department discharge summaries.<br><br>HGPH has a ward structure that provides appropriate accommodation for patients based on their clinical needs. Arrangements to cater for paediatric and end-of-life patients for example have been carefully considered. HGPH employs allied health clinicians from a range of disciplines. The allied health clinicians provide services in the acute setting and also manage a range of outpatient programs.<br><br>Every patient admitted to HGPH has a clearly identified VMO who has overall accountability for their care. |

| 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** | |
| HGPH has a variety of processes to support multidisciplinary collaboration, teamwork and care planning. This includes through VMO ward rounds, multidisciplinary craft group team meetings, family meetings, multidisciplinary case conferences, daily bed meetings, post fall huddles and a series of Operating Theatre team meetings and huddles.<br><br>Ward clinical handovers, including bedside handover, provide the nursing team with concise and relevant information related to patient care matters. Handover sheets printed from WebPAS are used to support nursing clinical handovers.<br><br>Assessors attended a number of the meetings/huddles/handovers and noted that they are efficiently and effectively managed.<br><br>Assessors were advised that there is close operational liaison between the nurse in charge in each ward and the relevant VMOs. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.06 | |
|---|---|
| Clinicians work collaboratively to plan and deliver comprehensive care | |
| **Comments** | |
| HGPH demonstrated a team approach to planning, documenting and delivering of comprehensive care, as described in the commentary in Action 5.05. | |
| **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** | |
| Healthscope has policies and procedures to support the integrated and timely screening and assessment of patients. Healthscope has also developed and implemented a series of risk screening and assessment tools and forms that are evidence based, logical to use and are applicable to the range of clinical services provided. The assessment tools and documents cover the risks of harm listed in the minimising patient harm criterion.<br><br>The Healthscope Comprehensive Risk Screening form provides summary information related to identified patient risks along with resultant actions. Processes to assess surgical risks pre-operatively and risks related to Emergency Department patients are also well established.<br><br>Important risks other than those listed in the minimising patient harm criterion are also considered during admission clinical assessments. This includes, for example, risks related to social situation, continence, substance withdrawal, medications, COVID-19 and other infections, venous thromboembolism, bariatric status and allergies. Further assessments and risk mitigation actions are undertaken, depending on the results of risk screening.<br><br>HGPH has undertaken a considerable amount work in the development of gap analyses and action plans related to the Comprehensive Care Standard ASQHC Advisories. Progress has been substantial and has included the embedding of processes to screen for and to assess risk of harm.<br><br>Assessors agree that the current requirements of the ASQHC Advisory AS18/14 "Comprehensive Care Standard: Screening and assessment for risk of harm", which is applicable to Actions 5.07 and 5.10, are met. | |
| **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 HGPH administration staff who undertake patient registration advised that asking the Aboriginal and/or Torres Strait Islander identity question is routine practice. Administration staff reported that they have had no issues with asking the question. The response to the question is entered into the Patient Registration form. Aboriginal and Torres Strait Islander status is also documented in WebPAS.<br><br>HGPH provides the "Are you of Aboriginal or Torres Strait Islander descent – why are you asked this question" brochure. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.09 | |
|---|---|
| Patients are supported to document clear advance care plans | |
| **Comments** | |
| The Healthscope Advance Care Directives Policy provides guidance in relation to the management of Advance Care Directives and Advance Care Plans.<br><br>Where an inpatient seeks to further discuss the completion of an Advance Care Directive or to develop an Advance Care Plan, general advice is given. Patients are encouraged to discuss the matter further with their treating VMO. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.10 |
|---|
| Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks |
| **Comments** |
| The admission process for all HGPH patients includes an overall clinical assessment of physical, cognitive, behavioural and mental health conditions that the patient may have. Medical, nursing and often allied health assessments are undertaken. Assessments also consider any other factors that may contribute to the overall health of the patient, for example the patient's social and family circumstances and ability to self-care. The assessment also includes a check for known allergies. Consideration of clinical risks is a key part of patient clinical assessment.<br><br>Where patients are booked for a pre-planned admission, the Patient Health History form is completed. This includes questions relevant to various risks the patient may have.<br><br>Where admission screens identify specific risks, processes, tools and pathways are in place to further assess the risk and to implement risk reduction strategies. Examples include the 4AT assessment tool and alcohol withdrawal chart. Additional or repeated screening may need to be undertaken during admissions, either scheduled, or as result of a change in the patient's condition.<br><br>In the case of overnight admissions, the Comprehensive Risk Screening form and the Comprehensive Care Plan form are used to provide a clear overview of the risks identified and the corresponding risk mitigation strategies that have been implemented.<br><br>Well established processes are in place to identify and minimise surgical and anaesthetic risks, including at the time the Theatre booking is made, during the admission process, during transfer to Theatre and during the surgical procedure.<br><br>Risk screening is also a routing part of the assessment of adult and paediatric patients presenting to the Emergency Department.<br><br>Assessors agree that the current requirements of ASQHC Advisory AS18/14 "Comprehensive Care Standard: Screening and assessment for risk of harm", which is applicable to Actions 5.07 and 5.10, are met. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 5.11 |
|---|
| Clinicians comprehensively assess the conditions and risks identified through the screening process |
| **Comments** |
| VMOs document admission information and nursing staff complete risk screening and care planning documentation. Where relevant, allied health clinicians also assess patients and document their findings. Clinical assessment processes applicable to each of the clinical services provided by HGPH are in place.<br><br>HGPH has series of processes, tools and pathways in place to support risk screening, risk assessment and the implementation of risk reduction strategies for all patients under its care.<br><br>The clinical evaluation and management of patients is supported by an onsite pathology service and a comprehensive onsite medical imaging service. |

| 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** |
| HGPH has a paper-based health care record. The health care record includes an appropriate range of forms to support the documentation of clinical assessments, risk screening, care plans and patient clinical progress.<br><br>The range of forms that are used to document clinical care at HGPH are in the main standardised across Healthscope sites.<br><br>Alerts are documented in the health care record and an entry is made into WebPAS. An entry is also made on the HGPH Alert sheet.<br><br>Assessors were advised that the Clinical Risk and Documentation Improvement Co-ordinator has made a significant impact on the consistency and quality of clinical documentation. |

| 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** |
| HGPH uses the Comprehensive Care Plan, the Comprehensive Care Plan – Daily IV Access and the Progress/Variation/Outcome Note forms to document the ongoing clinical status of patients, changes to clinical treatment that may be required and discharge planning. A range of supporting documents are also available, depending on the clinical circumstances and the clinical services being provided.<br><br>The result of medical imaging and pathology investigations, multidisciplinary case conferences and multidisciplinary craft group team meetings are also documented.<br><br>Patient goals of care are included into the care planning documents. Patient goals are also noted on the patient care boards in the ward rooms. Allied Health clinicians conducting outpatient programs develop "SMART" goals jointly with their patients.<br><br>HGPH has well established external referral processes. Internal referrals can be made through WebPAS.<br><br>HGPH ensures that there is appropriate family involvement in the patient's care, subject to the patient's wishes. The various care planning forms are used to document patient and family involvement in care. The Patient/Carer Consultation form is also used to document discussions with family and carers, particularly where the patient has cognitive impairment.<br><br>HGPH has access to allied health clinicians to support patient assessment and management. The Discharge Planners, the Clinical Risk and Documentation Improvement Co-ordinator and the Clinical Nurse Consultant - Wound Care each play very important roles in the care of patients.<br><br>Assessors agree that current requirements of ASQHC Advisory AS18/15 "Comprehensive Care Standard: Developing the comprehensive care plan" are 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** |
| The paper-based health care record is a key clinical communication tool that supports the development and monitoring of comprehensive care plans at HGPH. Documentation in health care records includes clinical history, physical examination, risk assessment, treatment plans, patient goals and discharge planning. WebPAS also provides access to some key information, including alerts and diagnostic investigation results.<br><br>HGPH monitors the progress of the care plan for inpatients in a variety of ways, including through VMO ward rounds, bedside clinical handover, multidisciplinary craft group team meetings, post fall huddles, Theatre huddles, multidisciplinary case conferences, repeated or additional risk assessments and ongoing clinical observation. There is also ongoing communication with the patient and family/carers.<br><br>A review of the care plan occurs where there are unexpected changes in the patient's clinical condition or following a clinical incident, such as a fall. A review of the patient's condition and possible alterations to the care plan is also triggered by abnormal or unexpected pathology or medical imaging results. Episodes of escalation of patient care also prompt a review of the care plan.<br><br>Assessors agreed that HGPH has well established systems in place to monitor the clinical care that patients receive, and to adapt care plans as relevant. |

| Rating | Applicable HSF IDs |
| --- | --- |
| Met | All |

| ACTION 5.15 |
|---|
| The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46] |
| **Comments** |
| HGPH provides inpatient end of life/palliative care on its Kendall ward. Kendall ward also caters for medical and oncology patients. There are no specific palliative care ward rooms. However, all rooms in the medical ward are modern and spacious. A single room or a double room can readily be adapted for the provision of end-of-life care. This includes providing a sofa for a family member to use.<br><br>Healthscope provides a comprehensive range of end-of-life resources through its Last Days of Life Toolkit which is accessed through the HINT site. The Last Days of Life Care and Management Policy provides clear guidance for HGPH staff. The Policy references the National Consensus Statement: Essential elements for safe and high-quality end-of-life care and incorporates the essential elements outlined in the consensus statement. The policy emphasises the need for joint decision making in the development of individualised holistic end-of-life care plans. The policy also describes decision making processes surrounding the identification of patients who are near the end of their life. The Initiating Last Days of Life Management Plan – Adult document also includes a section on the recognition of dying. The Comfort Observation and Assessment (COSA) Chart – Adult is used to documents symptoms and includes symptom management prompts.<br><br>Once consensus is achieved surrounding a shift to a palliative approach to care, HGPH places a Palliative Care Initiation sticker in the patient's medical record. The sticker clearly communicates to clinical staff that a palliative approach has been implemented. The sticker also includes a checklist of actions that need to be undertaken to support the palliative approach. This includes the completion of the Medical Orders for Life Sustaining Treatment (MOLST) document in partnership with the patient and/or person responsible. The MOLST document includes the patient's wishes regarding the escalation of care that is to be provided during the last days of life along with other treatment preferences. |

| 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** |
| End-of-life care is provided by HGPH ward nursing staff under the guidance of Palliative Care Physician VMOs. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 5.17 | |
|---|---|
| The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record | |
| **Comments** | |
| Patients are asked whether they have an Advance Care Directive during the admission process. The question is included in the Patient Health History form that patients complete prior to or during their admission. If patients have an Advance Care Directive in place, a copy is requested for filing in the health record. A record of the presence of the document is made in WebPAS, on the Alert Sheet and where relevant on the Palliative Care Initiation sticker. The presence of an Advance Care Directive is also recorded on bedside handover sheets. | |
| **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** | |
| HGPH staff can access support from Healthscope's Employee Assistance Program which is provided by Converge International. Support from managers is also provided and formal debriefing can be arranged. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.19 | |
|---|---|
| The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care | |
| **Comments** | |
| The provision of end of life/palliative care is evaluated on a case-by-case basis with oversight provided by the HGPH Mortality and Morbidity Committee. Feedback from patients and their families is also routinely and regularly monitored. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.20 | |
|---|---|
| Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46] | |
| **Comments** | |
| The Last Days of Life Care and Management Policy highlights the need for joint decision making regarding all aspects of end-of-life care. HGPH provides several written brochures to patients and families in a Last Days of Life Care folder. The brochures are informative and have been endorsed as Consumer Approved Publications. The Healthscope Last Days of Life Toolkit, which is accessed via HINT, also includes an excellent range of consumer resources.<br><br>Spiritual/pastoral care to support patients and their families is also available. | |
| **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 Healthscope Pressure Injury – Prevention. Identification and Management of Policy is a key document that provides guidance to clinicians regarding pressure injury risk assessment, prevention and management. The policy is detailed and references a variety of evidence-based resources.<br><br>Pressure injury risk screening and assessment is recorded on the HGPH Comprehensive Risk Screening form. The Waterlow screening tool is used to assess pressure injury risk. All patients receive basic pressure injury prevention interventions, with additional interventions implemented based on the Waterlow score. Interventions are recorded on the Comprehensive Risk Screening form.<br><br>The HGPH Clinical Nurse Consultant – Wound Care and the wound care team play a very valuable role in pressure injury prevention and wound management. This includes through outpatient wound clinics.<br><br>Well-designed and informative posters outlining the HGPH stomal therapy pathway, skin tear assessment and management and pressure injury management and prevention have been developed by the Clinical Nurse Consultant – Wound Care. |

| 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 assessments are a routine component of pressure injury risk screening and risk minimisation. The Healthscope Comprehensive Skin Assessment form is used to document skin assessments. Interventions that are required are documented in the skin assessment section of the Comprehensive Risk Screening form. Whenever there is a skin breach that requires dressing, the Wound Care Assessment and Plan form is also completed. Subject to patient consent, wounds are photographed to assist in the monitoring of wound management and healing. |

| 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** | |
| Pressure injury prevention and management involves discussions with the patient and where appropriate with the family and carer. This is noted on the Comprehensive Care Plan form.<br><br>Nurses and allied health clinicians are involved in the prevention and management of pressure injures, including the provision of patient education.<br><br>Patient information resources are available through HINT, the Healthscope intranet site. The Healthscope “Prevention of Pressure Injuries – information for patients” brochure is provided to patients and their families.<br><br>HGPH has a range of equipment and aids onsite to assist in pressure injury prevention and management. Staff training in the correct use of the aids and equipment is provided. | |
| **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** | |
| The Healthscope Falls Prevention and Management – Patient Policy provides guidance to clinicians regarding falls prevention and management.<br><br>Falls risk screening and assessment is recorded on the HGPH Comprehensive Risk Screening form. Several routine falls reduction strategies are implemented for all inpatients. Should the risk screen and assessment identify that the patient has a higher falls risk, a range of additional falls risk reduction strategies are implemented. Physiotherapy referral occurs for patients who have a high falls risk.<br><br>Following a fall, a RiskMan form is completed, an entry is made in WebPAS and an entry is made on the Alert Sheet. HGPH has implemented falls huddles following any patient fall. A falls huddle sticker is placed in the patient's progress notes. HGPH also activates a MET call for all unwitnessed falls to facilitate a thorough clinical review of the patient.<br><br>The allied health team run an outpatient Falls Prevention and Better Balance program. | |
| **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** | |
| HGPH has good access to a wide range of equipment and aids on site to support patient mobility and to assist in the prevention of falls. HGPH can also promptly access additional equipment if required through arrangements with private equipment supply companies. Patients are provided with options for them to access falls reduction equipment and mobility aids for use at home following discharge. | |
| **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** | |
| HGPH has patient information resources to supplement discussions with patients and their families regarding falls. This includes the Healthscope "Preventing Falls Patient Information" brochure. | |
| **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** | |
| The Healthscope Diet and Nutrition – Adult Inpatient Policy provides detailed guidance regarding the management of the nutrition of HGPH patients. HGPH clinicians also have access to series of supporting policies. This includes in relation to enteral nutrition, fluid balance charts, the use of naso-gastric tubes and bariatric patient management. The policy documents are well referenced, and evidence based.<br><br>The HGPH Comprehensive Care Risk Screening form includes the Malnutrition Screening Tool (MST). Actions to be undertaken, depending on the MST score, are included on the form. This may include referral to the dietitian. Where there are concerns regarding dysphagia, speech pathologist referral also occurs.<br><br>Assessors noted the very good cooperation between the catering service, the dietitian and the speech pathologist regarding the management of nutrition. | |
| **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 HGPH menu has been developed through collaboration between catering staff, the dietitian and the speech pathologist. Food is prepared onsite. A range of special dietary requirements are accommodated, and various food supplements are available. Processes to manage patients with food allergies are also in place.<br><br>Nurses monitor the nutrition and hydration status of their patients, including whether assistance or supervision with feeding is needed. The Food and Fluid Intake Record is used where appropriate to document food and fluid intake.<br><br>Education has been provided to nursing staff related to the completion of fluid balance charts and the management of Enteral Feeding and Total Parenteral Nutrition (TPN).<br><br>Assessors noted that the HGPH catering team are highly professional and demonstrate a great deal of pride in their work. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.29 |
|---|
| The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation |
| **Comments** |
| The Healthscope Delirium and Cognitive Impairment Prevention and Management Policy provides guidance regarding the screening, assessment and management of patients with cognitive impairment and delirium. The focus is on prevention, early detection and prompt management of delirium and cognitive impairment.<br><br>Patients presenting to the HGPH Emergency Department who are over 65 years old undergo a basic initial screen related to their memory. Further assessment is undertaken depending on the outcome of the screen. Patients being admitted for elective surgery complete a comprehensive Patient Health History pre-admission form that includes questions related to cognitive impairment related risks.<br><br>Patients undergoing ward admissions are screened using the Cognitive Impairment Risk Assessment Tool (CIRAT). The results are recorded on the Comprehensive Risk Screening form. Depending on the result of the CIRAT screen, a 4AT assessment test may be undertaken. Liaison with the family and carers occurs as appropriate and referral for further specialist clinical assessment may be arranged. A Behaviour Chart may also be commenced.<br><br>The Delirium and Cognitive Impairment Prevention and Management Policy, along with the Restrictive Practices – Patient Restraint (Non-Mental Health Facilities) Policy, provides guidance regarding the use of psychotropic medication. Psychotropic medication is only used as a form of restraint at HGPH in very limited and urgent situations and is subject to close monitoring and auditing. |

| 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** |
| The Delirium and Cognitive Impairment Prevention and Management Policy includes a comprehensive delirium screen pathway. The pathway provides guidance to clinicians on the screening, assessment, diagnosis and treatment of patients experiencing delirium. The pathway also provides advice on discharge planning and follow up care. Healthscope has also produced cognitive impairment and 4AT assessment flow charts to assist clinicians.<br><br>Patients who have cognitive impairment or are at risk of delirium are closely monitored by HGPH clinicians, including through the use of Behaviour Charts. “Specialling” can be arranged if required.<br><br>There is close liaison with the patient and family members with regards to delirium and cognitive impairment. The “Cognitive Impairment - Patient and Carer Information” brochure is used to support discussions with patients, family members and carers.<br><br>Assessors noted that HGPH has adopted the TOP 5 strategies program and the sunflower tool to support care and communication, particularly with patients with a cognitive impairment. The Family/Carer Consultation form is used to record discussions where the patient has cognitive impairment. The TOP 5 support strategies are considered and recorded on this form. |

| 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** |
| HGPH has a series of policies that provide guidance to clinicians in the management of patients at risk of self-harm or suicide. The Healthscope Self-harm and Suicide (Threatened, Attempted or Completed in a Non-Mental Health Facility) Policy in one of the key policy documents.<br><br>HGPH staff can access the Consultant Liaison Psychiatry Nurse Practitioner and VMO Psychiatrists where there are concerns about a patient's mental state, including those who are experiencing thoughts of self-harm or suicide. HGPH, however, does not have an impatient mental health unit and has limited capacity to provide ongoing management for patients experiencing significant mental illness. This is clearly delineated in the HGPH Inpatient Admission Exclusion Policy. In accordance with this policy, a patient experiencing significant mental illness, including being at risk of self-harm or suicide, will generally be transferred to another facility that can appropriately care for the patient.<br><br>Assessors noted that HGPH has provided training to staff in relation to the management of patients experiencing mental health illness and related behavioural problems.<br><br>The Consultant Liaison Psychiatry Nurse Practitioner has played a very important role in providing staff education and in the provision of consultation advice regarding individual patients. |

| 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** |
| Patients who have expressed suicidal ideation or are at risk of self-harm and who cannot be managed safely at HGPH are transferred to a public or private mental health service for further assessment and management. Ambulance Victoria generally provides the patient transfers, with Police assistance if needed. |

| 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 Healthscope Occupational Violence and Aggression (OVA) Incident Management – Principles and Prevention Policy provides guidance to HGPH staff regarding the management of aggression or threatening behaviour. The importance of prevention, early identification and de-escalation of potential aggression is highlighted. The policy also emphasises personal safety, appropriate staff training and the use of code black alerts where required.<br><br>Behavioural and substance withdrawal risk screening for inpatients is documented on the Comprehensive Risk Screening form. Should risk be identified? various mitigation strategies are implemented depending on the nature and the extent of the risk. Patients considered to be at risk of aggressive or unpredictable behaviour are closely monitored, including one to one observation/specialling if required. Behaviour Charts are also used where appropriate. A behaviour alert is also placed in webPAS.<br><br>The Emergency Department assesses patients for mental health, behavioural and substance abuse risks. Although the Emergency Department does not have a specific behavioural assessment room, areas are available that can be adapted to provide a quieter and less stimulating environment where required. | |
| **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** | |
| HGPH emphasises the importance of family and carer involvement, where appropriate, in the management of patients exhibiting difficult or threatening behaviour.<br><br>There is a focus on working together to develop a management plan to prevent or to rapidly de-escalate threatening behaviour and aggression.<br><br>Workplace Assessment Violence Education (WAVE) 1 training is mandatory for all HGPH staff. At the time of the Assessment, around 90% of staff had completed the online training module. The training focusses on predicting, preventing and de-escalating aggressive behaviour. Assessors were advised that WAVE 2 and WAVE 3 training will be a focus during 2022. It is planned that Melbourne Clinic staff will assist in the training.<br><br>Should an episode of aggression occur, HGPH has processes in place to support staff and, where necessary, patients, family members and carers. This may include the activation of a code black response. Activation of the code can be made through a 2222 call, including via DECT (Digital Enhanced Cordless Telecommunications) phones.<br><br>HGPH also has duress buttons in several locations. When a code black is activated, an internal response team is alerted by switchboard. The response team responds to the call, in accordance with the HGPH Emergency Procedure Manual. The Police are notified as part of the response. HGPH reported that code black activations are very infrequent and are subject to close post-incident review.<br><br>HGPH staff commented that occasional episodes of verbal aggression have been experienced related to frustrations borne out of COVID-19 restrictions. Staff members however are generally able to rapidly de-escalate the situation, underlining the benefit of WAVE training. | |
| **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** | |
| The Restrictive Practices – Patient Restraint (Non-Mental Health Facilities) Policy covers physical, chemical and environmental forms of restraint. The policy includes the use of bed rails. Physical or chemical restraint is very infrequently used at HGPH and only in circumstances where all less intrusive methods have failed. Patients who require or may require chemical, physical or environmental restraint are usually promptly transferred to a more appropriate facility. There is strict patient monitoring, as well as documentation and reporting requirements, including via RiskMan, should restraint be used.<br><br>Assessors noted that there is minimal use of bedrails at HGPH. Staff training in the use of bedrails has been provided. | |
| **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** | |
| Seclusion is not permitted and is not undertaken at HGPH. Assessors agree that this action is 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** | |
| The HGPH Communicating for Safety Committee provides governance oversight of the communicating for safety standard. The Committee has broad membership including representatives from each of the clinical areas.<br><br>Healthscope policies and procedures related to communicating for safety are available to staff members through the organisation's intranet, HINT. Key guiding documents consist of the Clinical Handover – Department and Intra-Unit Policy, the Patient Identification Bands Policy and the Correct Patient, Correct Procedure, Correct Site Policy. There are also several supporting policies related to various transfer of care situations, including patient discharge.<br><br>HGPH staff reported that they have very good access to education and in-service training. Effective communication and teamwork are common themes in staff orientation and in ongoing staff education. This includes training related to various aspects of clinical handover. Bedside handover and other communication processes were areas of focus in the Healthscope Back to Bedside initiative. | |
| **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** |
| The HGPH Communicating for Safety Committee meets two monthly. Matters related to communicating for safety are referred as relevant through the HGPH clinical governance system, including to the Comprehensive Care Committee, the Patient Care Review Committee and the Medical Advisory Committee. Relevant matters are also discussed at ward meetings.<br><br>HGPH has an annual audit schedule that includes several elements related to communicating for safety, including clinical handover, patient identification, Theatre time out and discharge planning. Results are reported to the Communicating for Safety Committee. Various KPIs are also displayed on Quality Boards in each of the wards.<br><br>Issues related to communication are considered during the review of clinical incidents and complaints. Where concerns are identified, feedback is provided to staff members. This includes through ward meetings and where appropriate via discussions with individuals. Further training may also be provided to individuals or groups where required.<br><br>Assessors noted that a number of quality improvement activities have been undertaken at HGPH related to communication for safety. Examples include the Orderly Transport Process to Radiology project and the development of the safety huddle and ISOBAR based bedside handover lanyard cards A significant quality improvement project to streamline pre-operative processes related to the various Visiting Medical Officer (VMO) surgeons and anaesthetists has also been undertaken. In addition, a Discharge Envelope with a checklist on the front has been implemented to ensure that all discharge documentation is consistently provided. Paterson Ward is conducting a quality improvement project aimed at improving the completion of fluid balance charts, including through staff education and the use of a prompt card.<br><br>Falls huddles have been instituted and inpatient rounding takes place and is documented.<br><br>HGPH has developed ward signage folders that contains a range of laminated cards that can be placed on the door of ward rooms to alert staff of specific patient care requirements or risks.<br><br>HGPH has appointed a Clinical Risk and Document Improvement Coordinator who has two overlapping roles. One is to support ward staff in all aspects of comprehensive care provision and the other is to promote high quality medical record documentation. The Clinical Risk and Document Improvement Coordinator has a strong daily ward presence and liaises closely with nursing and allied health clinicians, VMOs and the Health Information Service. |

| 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 Healthscope Consumers - Partnering with Policy provides advice to clinicians in a range of matters related to the provision of patient-centred care.<br><br>Assessors observed patient involvement in discussions with clinicians, including during bedside handover. Patient goals and preferences and clinical care options were discussed during rehabilitation team case conferences. There is a strong emphasis by allied health clinicians in joint decision making and goal setting in both the inpatient and outpatient clinical settings.<br><br>Ward patient care boards facilitate patient/family/clinician communication and consideration of goals of care. Family meetings are held where appropriate.<br><br>Assessors noted that HGPH has adopted the TOP 5 strategies program and the sunflower tool to support care and communication, particularly with patients with a cognitive impairment. The Family/Carer Consultation form is used to record discussions where the patient has cognitive impairment. TOP 5 support strategies are considered and recorded on this form.<br><br>HGPH has a wide range of brochures available which are provided to patients. This includes information regarding the admission process, discharge planning, and clinical bedside handover. There are also brochures related to the prevention and management of specific risks, such as falls, pressure injuries, infections and cognitive impairment. The brochures are each endorsed Consumer Approved Publications.<br><br>Assessors spoke to several patients who reported that they were very satisfied with the information they had received and their involvement in decision making. Qualtrics reports also indicate that HGPH patients have high levels of satisfaction with their overall care, the provision of information and their involvement in decision making. |

| 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** |
| Healthscope has a range of policies and procedures relevant to communicating for safety which provide guidance to HGPH clinicians. This includes in relation to patient identification, procedure matching and transfer of care. A range of health record forms that support the documentation of all aspects of patient care is also provided.<br><br>The development of the HGPH discharge envelope has been a very positive initiative. Nursing Discharge Summaries were noted to be particularly thorough. Separate medical discharge summaries are also completed. An inpatient Discharge Plan form is used where patients have complex discharge planning needs. Emergency Department patients are routinely provided with discharge summaries.<br><br>The Patient Inter-Hospital, Facility and Service Transfer Summary form is used to provide information on patients transferred to another facility.<br><br>Medical services for HGPH patients are provided by specialist VMOs. Assessors noted that there is a good level of communication between the VMOs and HGPH staff, including during ward rounds and at other times depending on patient needs. This includes where there is a need to communicate various types of critical information or to escalate care. VMOs also participate in scheduled case conferences and craft group multidisciplinary team meetings.<br><br>HGPH has established comprehensive processes related to the pre-admission assessment of prospective surgical patients. This supports patient safety through risk assessment and well considered admission and discharge planning. |

| 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 Patient Identification Bands Policy provides detailed guidance related to the use of patient identifiers. This includes the use of at least three identifiers whenever responsibility for care is transferred between clinicians. Further and complementary guidance regarding patient identification and procedure matching is provided by the Correct Patient, Correct Procedure, Correct Site Policy and the Clinical Handover – Department and Intra-Unit Policy.<br><br>HGPH uses single white patient identification bands apart from where there is a medication allergy/alert in which case single red bands are used. | |
| **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** | |
| Patient identification processes using at least three patient identifiers are well established throughout HGPH in a range of situations. This includes during medication administration and during bedside clinical handover.<br><br>Theatre sign in, time out and sign out processes incorporating the surgical safety checklist are well established, including in the Cardiac Catheter Laboratory.<br><br>Assessors noted that patient identification and procedure matching is undertaken at the onsite medical imaging service prior to the commencement of radiological investigations. | |
| **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** |
| The Clinical Handover – Department and Intra-Unit Policy and associated policies describe various clinical handover/transfer of care processes relevant to HGPH. HGPH uses the ISOBAR communication tool to standardise clinical handover processes. ISOBAR has been incorporated into tools and checklists that have been developed to support staff undertaking transfers of care. Examples include the Ward to Ward Transfer form, the Patient Inter-Hospital, Facility and Service Transfer Summary form and clinical handover sheets. The importance of patient/family/carer involvement is emphasised in the various tools and processes. |

| 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 Clinical Handover – Department and Intra-Unit Policy and associated policies outline processes to be followed in various transfer of care situations. Relevant tools and forms to support this are available to HGPH staff. Examples of documents in use include bedside handover summary sheets generated from webPAS, the inter ward transfer form and Theatre transfer documentation. Ward white boards link to webPAS and provide ready access to patient alerts and investigation results. Assessors reviewed relevant documentation in medical records and observed clinicians providing clinical handover/transfer of care. This included during bedside handovers.<br><br>Assessors agreed that HGPH has effectively implemented a range of robust clinical handover processes. Nursing staff were observed routinely engaging with patients during bedside clinical handovers. Assessors also received positive feedback from patients regarding their involvement in discussions with clinicians in general, including during clinical handover and ward rounds. HGPH ward patient care boards are useful communication tools that contain a range of information. This includes the name of the nurse looking after the patient for the shift, key activities that are planned and the likely discharge date. A range of Theatre huddles are routinely scheduled. These promote smooth patient flow and effective transfer of care. |

| 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** | |
| HGPH has processes in place to manage the communication of critical information relevant to the particular situation. HGPH Nurse Unit Managers and Hospital Coordinator have key roles in ensuring that critical information is communicated as required. This may involve contacting the relevant VMO should the patient deteriorate or there is an unexpected change in the patient's physical or mental condition. Discussions with the patient/family also occur.<br><br>Significantly abnormal or unexpected pathology or medical imaging results are communicated directly to the relevant VMO by the pathology scientist or radiologist as well as to ward nurse in charge. | |
| **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** | |
| HGPH staff regularly engage with their patients, including through regular rounding and during bedside handover. HGPH staff also regularly engage with the patient's family in accordance with the wishes of the patient. Patients and family members are encouraged to relay new or additional information that they may have, or to express concerns to the treating VMO or nursing staff. Family meetings may also be arranged.<br><br>A copy of the "Your Rapid Response Process" brochure is provided to patients as part of the admission process. | |
| **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** |
| HGPH uses a paper-based health record that includes a host of forms to document patient demographic and clinical information.<br><br>A series of risk screening and assessment tools are completed relevant to patient's clinical care needs. A range of allied health specific assessment documents are also in use, including for outpatient programs. Key inpatient documents include the Comprehensive Risk Screening form, the Comprehensive Care Plan form and the Clinical assessment form. The Progress/Variation/Outcomes Note form is used to document inpatient clinical progress, care outcomes and, where relevant, changes to the care plan.<br><br>The Standard Adult General Observation (SAGO) and (where appropriate) a series of age-related Paediatric observation charts are used to document and monitor the physiological observations of ward inpatients. Emergency Department, Intensive Care and Theatre specific observation charts and documents are also in use.<br><br>HGPH uses the Alert Sheet to document significant patient alerts, including adverse drug reactions. Alerts are also entered into webPAS. Wards each have a white board linked to webPAS that provides ready access to patient alerts and investigation results. |

| 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** | |
| The Transfusion (Blood) Committee is Advisory to the Hospital Executive. Policies and procedures are approved by this committee under the Healthscope governance framework. This committee monitors and evaluates clinical outcomes to make appropriate recommendations. It fosters and facilitates the clinical governance and accountability for the standards and performance in relation to National Standard 7: Blood and Blood Products. The committee minutes had evidence of broad representation across key clinical areas and a focus on improvement processes and activities.<br><br>Clinical incidents are registered on RiskMan and a comprehensive report is undertaken. The Transfusion committee monitors these reports.<br><br>Staff compliance with BloodSafe education/training modules is monitored. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| The Transfusion (Blood) Committee is Advisory to the Hospital Executive and oversees Blood management at HGPH reporting through to Healthscope. Healthscope governance guides the HGPH outcomes reporting and monitoring to ensure compliance with the standard. Evidence was provided of a peri-operative massive blood loss resulting in the implementation of the massive transfusion protocol. The RCA identified issues with implementation of the Healthscope protocol and HGPH adapted the protocol to align with the local response including a flow chart to ensure out-of-hours access to urgent blood. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| The Transfusion (Blood) Committee is Advisory to the Hospital Executive. The committee minutes had evidence of advancing consumer brochures with the Consumer Advisory Committee, monitoring consumer satisfaction, compliments and complaints. The Assessors observed patient brochures on blood transfusion and blood consent with the consumer approval tick. The Assessors observed bedside handovers where patients were included in the handover supporting shared goals and decision making. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| The blood audits indicate overprescribing with normal haemoglobin levels however this does not take into account the day infusion centre where chronic and palliative care patients require multiple transfusions and prescribing outside the guidelines. | |
| **Suggestion(s) for Improvement** | |
| That audits are undertaken separately for the day infusion centre to clarify any issues specific to that area and to enable identification of any issues specific to the acute services. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.05 | |
|---|---|
| Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record | |
| **Comments** | |
| The Assessors had access to patient medical records for transfusion patients and generally the documentation was compliant. Compliance of documentation of consent shows room for improvement. The MAC Newsletter 2021 Q3 included a reminder to VMOs to ensure completion. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| The Transfusion Committee provides feedback and recommendations to the Quality Committee and Clinical Review Committee and medical craft groups via HGPH Executive. The MAC Newsletter highlights areas of focus for improvement including blood consent documentation inclusive of the indication for transfusion.<br><br>Healthscope provides a governance policy and reporting framework in accordance with the national guidelines and national criteria. Audits are conducted and any issues raised with clinicians. BloodSafe eLearning is supported by Healthscope. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.07 | |
|---|---|
| The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria | |
| **Comments** | |
| Blood management incident reports and adverse events are monitored and acted on. A recent post-operative haemorrhage incident revealed a failure of the Massive Blood Transfusion Protocol to accommodate local conditions. HGPH has rectified this situation with the development of a local HGPH flowchart as an Addendum to the Healthscope policy. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.08 | |
|---|---|
| The health service organisation participates in haemovigilance activities, in accordance with the national framework | |
| **Comments** | |
| HGPH participates in haemovigilance activities in accordance with the national framework. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| The Assessor followed a blood "journey" from entrance / registration, storage including maintaining the cold chain integrity, to distribution and handling of blood products safely and securely. | |
| **Rating** | **Applicable HSF IDs** |
| Met | 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** | |
| HGPH under the governance of Healthscope has policies and procedures to guide management and availability of blood and to eliminate wastage. The laboratories were able to provide evidence of this at survey through to the storage and management in theatres. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 8 - Recognising and Responding to Acute Deterioration

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

| **ACTION 8.01** |
|---|
| 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** |
| The HGPH Clinical Deterioration Committee has broad and relevant membership and provides governance oversight of the recognising and responding to clinical deterioration standard. HGPH has an array of policies and procedures to guide staff members in recognising and responding to acute deterioration in the variety of clinical situations that are relevant to HGPH. Most of the policies are Healthscope wide. Some, however, are HGPH specific, for example to reflect the composition of the local response teams. Overarching guidance is provided by the Healthscope Clinical Deterioration, Recognising and Responding to Policy. The approved policies are readily accessible to staff members via the Healthscope intranet, HINT. Assessors noted that each policy document has a section that clearly outlines the key elements of the policy. HGPH has a well-established risk management monitoring system, both at the corporate level and within HGPH.<br><br>HGPH has a strong focus on training and ongoing education which commences at orientation and induction. Basic Life Support (BLS) training is mandatory for all clinical staff. Adult Advanced Life Support (ALS) training is also mandatory for defined groups of clinicians. This includes Nurse Unit Managers, Hospital Coordinators and Emergency Department and Intensive Care clinicians. Two HGPH clinicians are qualified ALS trainers. ALS training levels are high the amongst key clinical personnel. Paediatric Advanced Life Support training is also provided to key clinical personnel, including in the Emergency Department.<br><br>Training in the use of track and trigger charts is provided at orientation. Laminated ready reference guides on the use of the charts are placed inside each inpatient bedside folder. The Fundamentals of Nursing education series covers a number of clinical areas, including the management of clinical deterioration. Training in the assessment and management of patients with mental illness is also provided, and mental health-related training is supported by clinicians from the Melbourne Clinic. HGPH simulation training includes scenarios in which the patient has suspected COVID-19 infection. Paediatric Infant Perinatal Emergency Retrieval (PIPER) clinicians also provide training to HGPH staff.<br><br>Assessors acknowledge the efforts of the HGPH education team in implementing the Training into Critical Care (TICC) program. This program has enabled the upskilling of several HGPH nurses. |

| **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** | |
| The Clinical Deterioration Committee meets quarterly and reports to the HGPH Patient Care Review Committee. Relevant matters are also reported to the Medical Advisory Committee. The HGPH Executive team also closely monitors clinical governance activities throughout the organisation.<br><br>Healthscope-wide shared learnings, including those related to identifying and responding to clinical deterioration, are considered through the HGPH clinical governance framework. HGPH also participates in the Healthscope Webex clinical deterioration special interest group.<br><br>HGPH uses its clinical incident reporting system, RiskMan, to identify all episodes of escalation of care. Data related to every code blue and MET call activation is entered into a reporting database. Each individual case is promptly reviewed by the Intensive Care Unit (ICU) Nurse Unit Manager. Senior ICU and Emergency Department medical staff assist in the review process. Support is also provided by the HGPH Quality and Education teams. Assessors noted that the reviews are thorough, with a range of aspects of clinical care considered. This includes for example the appropriate use of the sepsis pathway and the Medical Orders for Life-Sustaining Treatment (MOLST) form. The timely review process enables prompt actions to be carried where appropriate following each escalation of care. The HGPH Clinical Deterioration Committee reviews collated code blue and MET call data whilst the Mortality and Morbidity Committee also reviews selected individual cases.<br><br>Assessors noted that all cases of unwitnessed falls trigger a MET call activation. This is a valuable HGPH initiative which facilitates a prompt clinical review of every patient who experiences an unwitnessed fall.<br><br>The implementation of the stroke management pathway which has been developed in conjunction with Monash Health is a particularly noteworthy HGPH quality improvement initiative. Assessors also noted the substantial amount of work that has been undertaken to introduce the HGPH sepsis pathway. | |
| **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** | |
| The Healthscope Consumers - Partnering with Policy provides advice to clinicians in a range of matters related to the provision of patient-centred care. Various policies and procedures that cover the range of clinical services provided by HGPH emphasise shared decision making and goal setting.<br><br>HGPH has well established processes to engage with its patients during their care. This includes through admission assessments, ward rounds, bedside handover, patient rounding, the use of patient care boards and where relevant, family meetings. Each of these provide opportunities for discussions regarding patient care including potential clinical deterioration. A range of "Consumer Approved Publications" are also available to patients and their families, including the "Your Rapid Response Process" brochure.<br><br>Qualtrics patient experience data along with verbal feedback provided by patients to Assessors indicate that HGPH patients have a high level of satisfaction with their overall care, the amount of information they receive and their involvement in decision making. | |
| **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** | |
| HGPH uses a range of track and trigger observation charts. Colour coded track and trigger methodology is used, with corresponding escalation responses described on the charts. The Standard Adult General Observation Chart is commonly used. However, HGPH also uses specific emergency department, intensive care and anaesthetic observation charts, and a series of age specific paediatric observation charts is also available. Assessors reviewed several charts of inpatients and noted that they are in general being used appropriately. Nurses commented that they find the charts straightforward to use and provide a clear picture of the patient's physiological status. | |
| **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** |
| The Healthscope Delirium and Cognitive Impairment Prevention and Management Policy is a key resource that guides clinicians in the management of delirium, impaired cognition or impaired mental state. The policy includes a concise delirium screen flowchart.<br><br>The Comprehensive Risk Screening form, the Comprehensive Care Plan form and the Comprehensive Care plan - Daily IV Access form include components related to risk screening, assessment and management of mental health, behavioural or cognitive issues that patients may be experiencing.<br><br>HGPH has a number of mental health risk screening and assessment tools that are available. The most used are the Cognitive Impairment Risk Assessment Tool (CIRAT) and the 4AT assessment test. Individual patient management depends on the risk assessment and clinical findings. A Behaviour Chart is used when indicated.<br><br>HGPH clinicians have access to a Consultant Liaison Psychiatry Nurse Practitioner and appointed Visiting Medical Officer (VMO) Psychiatrists who provide mental health expertise.<br><br>Assessors agreed that HGPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory "AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state". This is applicable to Actions 8.05, 8.06 b, c, d and e, and 8.12. |

| 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 Healthscope Clinical Deterioration, Recognising and Responding to Policy provides key guidance to clinicians regarding escalation of patient care. The principles outlined in the policy are applicable across the range of clinical services provided by HGPH. A number of supporting Healthscope policies, for example related to mental health and pain management, are also available. In addition, a small number of HGPH policies are in place, in particular relating to the specific code blue and MET call response arrangements that are applicable to the organisation.<br><br>The combined resource documents cover escalation of care related to physiological, mental state or behavioural deterioration. The documents emphasise the importance of thorough documentation in the health care record and the use of the appropriate track and trigger observation charts. The importance of liaising with the patient and family members following any rapid response team activation is also highlighted.<br><br>HGPH clinical staff maintain regular ongoing engagement with patients, and where appropriate, their families, in a variety of ways. Nevertheless, should patients or family members have unresolved concerns, they are able to escalate care. The HGPH “Your Rapid Response Process” brochure describes how the patient or family member can escalate care.<br><br>HGPH clinicians are guided by Advance Care Directives and Medical Orders for Life-Sustaining Treatment (MOLST) in relation to escalation of care. These documents ensure that the wishes of patients are clearly recorded and acted upon.<br><br>Assessors agreed that HGPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory “AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state”. This is applicable to Actions 8.0, 8.06 b, c, d and e, and 8.12. |

| 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** |
| The Healthscope Clinical Deterioration, Recognising and Responding to Policy includes a provision for a patient or family member to directly escalate care. This is supported by the Escalation of Care and Rapid Response by Patient, Family or Carer Policy.<br><br>The "Your Rapid Response Process" brochure describes how a patient or family member can escalate care. Assessors were advised that this very infrequently occurs and generally reflects the need for additional communication. |

| 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 HGPH workforce can call for emergency assistance through emergency call buttons located in wards and other clinical care areas. Activation of the MET call team or code blue can be made at any time through calling 2222. Senior clinical staff also carry DECT (Digital Enhanced Cordless Telecommunications) phones that facilitate emergency response activations if required.<br><br>HGPH has a fleet of standardised resuscitation trolleys located throughout the organisation. Resuscitation trolleys are accompanied by paediatric specific emergency trolleys in the areas where paediatric patients may be managed (the Operating Theatre, Recovery, the Emergency Department and Dennis ward). A regular resuscitation trolley checking regimen is in place. This includes daily checks of the defibrillator and weekly checks of the entire trolley. Plastic ties are placed to secure the resuscitation trolleys after each weekly check has been completed.<br><br>Assessors noted that a clinical deterioration assessment tool using the ISOBAR format has been developed, laminated and placed on resuscitation trolleys. This provides clinical prompts to assist nurses in their assessment of patients. Laminated stroke clinical pathway guides have also been placed on the trolleys. Covid kits that include Personal Protective Equipment (PPE) are available to support rapid responses for suspected or confirmed COVID-19 cases. |

| Rating | Applicable HSF IDs |
|---|---|
| Met | All |

| ACTION 8.09 | |
|---|---|
| The workforce uses the recognition and response systems to escalate care | |
| **Comments** | |
| Escalation of care is well covered at HGPH orientation and during induction to specific clinical areas. This supplements the policy guidance which is accessible to all HGPH staff members via the Healthscope intranet site, HINT. Lanyard cards that summarise clinical review and MET call criteria also provide guidance to nursing staff.<br><br>Assessors spoke to HGPH staff members all of whom were aware of the process to escalate care. | |
| **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** | |
| BLS is classified as mandatory training for all HGPH clinical staff. Nurse Unit Managers closely monitor BLS training compliance in their clinical areas. Compliance rates are recorded on ward quality boards.<br><br>Paediatric specific resuscitation training is provided to clinicians working in relevant clinical areas, particularly in the Emergency Department. | |
| **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** | |
| Advanced Life Support (ALS) training is provided to senior nursing staff, including Nurse Unit Managers, Associate Nurse Unit Managers and Hospital Coordinators. All medical staff working in the Emergency Department and the Intensive Care Unit are all trained in ALS.<br><br>HGPH has an ICU Fellow rostered overnight, thus ensuring prompt high level medical support to nursing staff. | |
| **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** | |
| HGPH has established policies and procedures to manage patients with deteriorating mental state. This includes patients in the Emergency Department as well as those in other ward or clinical areas. On occasions, referral to the public mental health service for further management under an assessment order may be appropriate. Transfer of patients is generally provided by Ambulance Victoria.<br><br>Assessors agreed that HGPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory “AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state”. This is applicable to Actions 8.05, 8.06 b, c, d and e, and 8.12. | |
| **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** | |
| Patients who require higher level clinical care are transferred to an appropriate health care facility. This may be a public or a private facility depending on the nature and severity of the clinical condition and patient/family preference.<br><br>HGPH clinicians indicated that Ambulance Victoria provides a prompt response to 000 calls.<br><br>HGPH uses the Healthscope Patient Inter Hospital, Facility and Service Transfer Summary form to assist in the provision of all relevant information to the receiving health service. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Recommendations from Previous Assessment

Nil