NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Final Report

Prince of Wales Private Hospital

RANDWICK, NSW

Organisation Code: 120001
Health Service Organisation ID: Z1010011
ABN: 85/006/405/152
Assessment Date: 27-29 June 2023

Accreditation Cycle: 1

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the rating scale outline below:

Rating	Description
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. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.
Rating	**Description**
Not met	Part or all of the requirements of the action have not been met.

Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.
Not assessed	Actions that are not part of the current assessment process and therefore not reviewed.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**

For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.

Telephone: 1800 304 056

Email: AdviceCentre@safetyandquality.gov.au

Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *NSQHS Standards Second Edition Version 2*. This approval is current until 31st December, 2024.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Marjoree Sehu	Yes
Lead Assessor	Marrianne Beaty	Yes
Assessor	Sandra Polmear	Yes
Assessor	Shane Combs	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Prince of Wales Private Hospital. The accreditation decision was made on 14/08/2023 and Prince of Wales Private Hospital was notified on 14/08/2023.

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

Prince of Wales Private Hospital underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 27/06/2023 to 29/06/2023. The NS2.1 OWA required four assessors for a period of three days. Prince of Wales Private Hospital is a private health service. Prince of Wales Private Hospital was last assessed between 30/7/2019 – 2/8/2019.

PICMoRS was used to conduct this assessment, with 68% of available time was spent in operational areas during this assessment.

EXECUTIVE SUMMARY
Prince of Wales Private Hospital (PoWPH) is a moderate sized hospital co-located with three public hospitals in the Randwick Precinct. The other hospitals within the precinct included the Prince of Wales (PoW) Public Hospital, The Children's Hospital, and the Women's Hospital. Three assessors and a supervised trainee assessor conducted an on-site assessment against all NSQHS Standards as well as a maturity audit of the Clinical Trials Clinical Governance Framework. The organisation was assessed using PICMoRs methodology and achieved a 'Met' rating for all action. There were no previous recommendations that required closure. The organisation was found to be an excellent example of 'Short Notice Assessment Program (SNAP) ready' with all staff keen to share their knowledge, views, and opinions with the assessment team. All patients, carers and families spoken to by the team provided feedback that was very positive and heartfelt.

CLINICAL GOVERNANCE
The PoWPH leadership team, via specified role descriptions and committees review incidents, monitor KPI's and act to ensure the progression of the safety and quality agenda. It was evident on assessment that the governing body was thorough in its approach to safety and quality and the CEO sets the organisational culture through engaging personally with the communities, patients, and especially with the workforce who rely on the hospital. Systems are in place to identify patients from diverse backgrounds and high-risk groups who present for care and to ensure risks are appropriately managed. Assessors observed initiatives that Aboriginal and Torres Strait Islander health needs were identified, and cultural responsiveness was continually growing and improving. There is a strong clinical governance framework and the assessors observed this being effectively applied by a visibly present executive and leadership team. Evidence such as consumers being consulted about the new buildings indicated that consumers are involved in health service decisions.

The systems for managing safety & quality, risks, incidents, complaints, and feedback are robust and well-functioning. There are governance processes that demonstrate organisation-wide quality improvement systems that allow the organisation to effectively monitor and report on its performance against agreed indicators. PoWPH provided detailed evidence that was reviewed by assessors during the assessment and demonstrated they undertake high-risk reviews as detailed in Fact Sheet 14 - Assessing high risk scenarios. Credentialling, scope of practice and education and training were well defined and functional. AS18/11 in relation to My Health Record is met.

PARTNERING WITH CONSUMERS
Partnering with Consumers is supported by a small very proactive committee. Ongoing support and review of services has been markedly impacted by the COVID-19 pandemic. During this time, the committee continued to review documentation and patient information brochures. The appointment of the new Quality Manager has supported the resurrection of many of their on-site performance review activities that were well established prior such as consumer rounding as one

example. Of note is the representation of a consumer in the Patient Care Review Committee. PoWPH is compliant with the ACSQHC's Advisory AS18/10: Informed financial consent.
The numbers of patients that identify as Aboriginal and Torres strait Island origin are very small however the organisation actively monitors this information as part of the admission process. Of note is the work that PoWPH has undertaken to ensure compliance to these actions. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.

PREVENTING AND CONTROLLING INFECTIONS
The infection prevention and control program at the PoWPH is managed in conjunction with HICMR. There are well established contemporary infection prevention strategies that is reflected in the policy. There is good training of staff which is reflected in the high completion rates of the various training modules. The program is well coordinated and demonstrates ongoing quality improvement through projects undertaken in response to audit findings. There is ongoing consumer engagement with representation at the Infection Control Committee. The PoWPH is well supported by the CSSD, cleaning and environmental services. The antimicrobial stewardship initiative at the PoWPH is maturing into a multidisciplinary program with the recent appointment of an Infectious Diseases Physician.

MEDICATION SAFETY
The organisation has a mandatory requirement for all relevant clinical staff to undertake Med+Safe education. The current compliance rate is 98%. The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. Records reviewed by members of the assessment team confirmed their consisted use. Compliance with documenting medication related alerts is 87%.

COMPREHENSIVE CARE
Comprehensive Care systems are well established across all specialties. Care is coordinated in partnership with the patient depending on the specialty across the continuum of care. Care planning is aligned to the patient’s expressed goals of care and their health care needs. Health risks of harm are identified before and during admission. Strategies to manage the identified risks are implemented and monitored through targeted screening, assessment and intervention, planning care and the delivery of care to support safe patient care outcomes. PoWPH meets the requirements of the ACSQHC's Advisory AS18/14 Comprehensive Care Standard Screening and assessment for risk of harm and Advisory AS18/15 Comprehensive Care Standard: Developing the comprehensive care plan.

COMMUNICATING FOR SAFETY
Training for communicating for safety includes correct site surgery which currently has a compliance rate of 96%. Additionally, there is training called “Relationship centred caring” which covers National standards 5 and 6. The current compliance rate is 76% with the organisation undertaking active measures to increase this compliance rate.

BLOOD MANAGEMENT
The organisation monitors the blood management process in terms of blood and blood product utilisation, quality and safety and patient outcomes. Reports are provided to the Standard 7 Working Group and clinicians. PoWPH also participates in the Campus Transfusion Committee which involves Prince of Wales Public Hospital, the Royal Women's, Sydney Children's Hospital, and the Eastern Heart Centre and PoWPH. This Campus Transfusion Committee allows the opportunity for each hospital/facility to share learnings from any clinical events.

RECOGNISING AND RESPONDING TO ACUTE DETERIORATION
Risks and training needs are identified, and training records were made available to members of the assessment team. Current compliance for BLS is 96%. The organisation has collaborated with the

Resident Medical Officers with current compliance at 80%, with 100% soon to be achieved. There is also greater than 95% compliance for specific clinical competences such as Neonatal and Advanced Neonatal Resuscitation.

Summary of Results

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

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

Sites for Assessment

Prince of Wales Private Hospital

Site	HSFID	Address	Visited	Mode
Prince of Wales Private Hospital	101011	Barker Street RANDWICK NSW 2031 Australia	Yes	On Site

Shared and Contracted Services

The following contracted services are used by Prince of Wales Private Hospital.

Provider	Description of Services	Verified During Assessment
Chemtronics	Biomedical Engineering	Yes
Schneider Electrics	Building Management Systems	Yes
Veolia Pty Ltd	Clinical Waste	Yes
Arrow Pty Ltd	Confidential Waste	Yes
Clean Away Daniels	General Waste	Yes
Amcor Pty Ltd	Paper and Cardboard Waste	Yes
BGIS	Electric Boards	Yes
Grosvenor	Fire Alarm Systems	Yes
Grosvenor	Fire Extinguisher inspections	Yes
Grosvenor	Fire Safety Inspection & Maintenance	Yes
Lotus	Catering Filter Maintenance	Yes
Gallay Ecolab	Washer Disinfector	Yes
Malone Hospital Services Pty.Ltd.	Bed Pan Flusher	Yes
BOC - Corporate	Medical Gases (cylinders)	Yes
Coregas	Medical Gas Supplies(piped)	Yes
Spotless	Linen	Yes
Hobart Food Equipment	Catering Equipment Maintenance	Yes
Sydney Children's Hospital	Paediatric Resuscitation	Yes
Public Hospital Staff (Private 'arm')	Perfusion Services	Yes
HPS Pharmacies	Pharmacy - Corporate	Yes
Southern Cross Intensive Care Group	Intensive Care Services	Yes
NSW Health Pathology Laboratory (Eastern)	Pathology	Yes
Campus Security Prince of Wales (Public) Hospital	Security	Yes
Converge	Employee Assistance Program	Yes
Malone Hospital Services Pty Ltd	Sanitiser	Yes
BGIS	Mechanical & Air Conditioning Services	Yes
David Power PTY LTD	UPS's Theatres	Yes

Provider	Description of Services	Verified During Assessment
Gallay Ecolab	PreVacuum Sterilisers CSSD	Yes
Schindler Lifts Australia Pty Ltd	Lifts	Yes
Commercial Pest Control Systems	Pest Control	Yes
Chemsal	Removal of fluorescent Lights	Yes
Print Media Group	Printing	Yes
IMED Radiology	Radiology/MRI	Yes
Baby face photography	Photography	Yes
ABC Couriers - Corporate (as part of Quebec contract)	Courier	Yes
St Vincents Transport and Paramedical	Patient Transport	Yes
Royal Hospital for Women	Neonatal Resuscitation	Yes
Broadoak Carpentry PTY LTD	Carpentry Services	Yes
BGIS - Yarrawarrah Plumbing PTY LTD	Plumbing Services	Yes
Coldway Refridgeration P/L	Refrigeration - catering	Yes
Sharp Conditioning Solutions	Refrigeration - medical	Yes
Testel	Electrical Safety Testing	Yes
Ltak Services	Bed Maintenance	Yes
JB Medical	Pressure Injury Prevention Mattress	Yes
Hills Health Solutions	Nurse Call/Paging	Yes
Spirax Sarco & JCV P/L	Seam Control & Piping	Yes
Independent Airflow Services	Theatre Airflow/Filters	Yes
Corporate Sign Industries	Signage	Yes
NSW Boiler Inspection Services	Pressure Vessel Inspections	Yes
Independent monitoring Consultants	TMV Legionellae Plate and Count	Yes
Stokes Perna	Site Safety Audit	Yes
JHA Electrical	Electrical Works	Yes
Back to Basics Electrical Services P/L	Emergency Lighting	Yes
Progroup Automations PTY LTD	Access Control	Yes
Simplex	Theatres Timekeeping Clock Maintenance	Yes
Healthy Clean Services	Blinds-Cleaning of	Yes
SKG Cleaning Services	Theatres - night cleaning	Yes
Bayton Health Support Services	Common area - cleaning	Yes
Gallay Ecolab	Batch Chemistry System	Yes
in Vitro Technologies	Drying Cabinet	Yes
Invitro technologies	Ultrasonic cleaner	Yes
Gallay Ecolab	Steam Steriliser	Yes
Steris	Low temp steriliser	Yes
Medical devices	Hi Pot Insulation tester	Yes

Provider	Description of Services	Verified During Assessment
Precision Medical	MaQS tracking system	Yes
Pentax Medical	Plasma Typhoon	Yes
In vitro Technologies	Endoscope Washer	Yes
In Vitro Technologies	Endoscopy Drying Cabinet	Yes
Chemtronics	Gas Services	Yes

Prince of Wales Private Hospital has reviewed these agreements for the listed services in the 3 years preceding this assessment.

Standard 1 - Clinical Governance

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

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Comments	
In line with the requirements of the ACSQHC (Commission's) checklist for assessors (Reviewing information accessed and actioned by the Governing Body), the assessment team both observed and located sufficient documentation in the form of minutes, Terms of Reference, standing agenda items, Clinical and Key Performance Indicator Reports including external benchmarking, Risk Register and Clinical Incident Reports as well as Quality Improvement Activity reports. These all supported what the assessment team had been told during interviews with key clinical senior leaders and senior clinical staff across the organisation and witnessed during observation and discussions with staff on the floor. There was a very robust and widespread culture of safety and quality improvement that had been established and was being maintained amongst all staff in the organisation, no matter what their role. There was a palpable connection between the leadership team who set the organisation's strategic direction and staff at every level in the organisation demonstrating clear lines of communication which was a pleasure to observe. The organisation strongly utilises and supports the Healthscope Clinical Governance Framework which clearly describes the governance related roles and responsibilities across the whole service. This also encourages staff to effectively partner with patients and families and provide a wonderful patient-centred model of care. The Executive Leadership Team (ELT), along with the Patient Care Review Committee (PCRC) and the Medical Advisory Committee (MAC) monitored the effectiveness of the Clinical Governance Framework through their complaints and clinical incident reporting systems, internal audit program and data analysis. All aspects of the clinical safety and quality systems are underpinned by a risk management approach.	
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	
Issues of and accountability for the Aboriginal and Torre Strait Island specific Actions is by the PoWPH Quality and Safety Committee and the Executive Leadership Team. There are a range of Healthscope special documents including the Healthscope Reconciliation Plan and the Aboriginal and Torres Strait Islander Engagement Plan. The Acknowledgement to County is undertaken according to PoWPH policy. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
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	
Senior Managers and Clinicians were able to explain to the assessment team how the Clinical Governance Framework was utilised to guide safe and high-quality care for their patients. The Executive described how the strong culture of safety had been created by ensuring that staff on the National Standards working parties were constantly replaced by another member of staff on the same ward or department so that they all understood what was required of them to implement the National Standards, thereby improving the safety and quality of care provision. They also then learned what changes had been made because of the monitoring and reporting of its effectiveness and the need to create a strong 'culture of safety' within the hospital. Staff on the floor were very committed to providing a safe environment for their patients and when asked, said that they felt 'safe' about speaking up for safety, should they witness something that possibly could go wrong.	
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	
PoWP have introduced the PoWPH Cultural Diversity Plan, the Aboriginal and Torres Strait Islander Engagement Plan, and the Healthscope Reconciliations Plan as approved by Reconciliation Australia. An endorsed range of KPIs have been developed for ongoing monitoring of specific Aboriginal Torres Strait Island Actions to the Executive Leadership Team and Consumer Advisory Committee. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
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	
The assessment team conducted interviews with the Executive, Senior Managers and VMOs on the Medical Advisory Committee (MAC) to investigate the organisation's consideration of the safety and quality of health care for patients in its business decision-making. It was obvious in this organisation that high-quality care is being always considered and the safest cutting-edge technology is being sought to avoid lower than expected clinical outcomes and reduced length of stay for patients. This is based on the clear knowledge that there is a correlation between the length of time a patient is hospitalised and the likelihood of an adverse event occurring. The review of minutes of relevant committee meetings (especially the MAC) confirmed that issues of safety and quality are key factors in the organisation's business decision making and their acceptance of the conduct of clinical trials to further enhance both patient care and safety. Examples included the purchase of robotic equipment in the operating suite to improve the outcome of surgical procedure precision, the refurbishment of the organisation to make it more appealing to Aboriginal and Torres Strait Islander people, and the purchase of new technology to aid in the safety of basic activities conducted by staff every day, such as locating veins in ICU for IV lines, to name but a few.	
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	
Interviews with the Chair of the Medical Advisory Committee (MAC) and two other senior members of this committee reinforced that clinical leaders work within the governance framework, closely monitoring and acting of any areas of concern that arise. The MAC meeting covers several areas including any serious adverse event (AE) (which then are taken through the Patient Care Review Committee (PCRC)) and a deep investigation to determine contributing factors and mitigation strategies to prevent the AE from recurring within the organisation. The MAC also discuss the opportunities that may arise out of the conduct of clinical trials for their patients, and this is consistent with the process with the co-located Prince of Wales Public Hospital, the Children's Hospital and the Women's Hospital as well. Although not a large part of the PoWPH's practice, there are several very highly qualified and experienced Clinical Research Investigators working as VMOs who run up to 15 clinical trials in combination with the Randwick Precinct at any one time. During this assessment, an Assessment of the Maturity Status of the PoW Private Hospital's Clinical Trials Clinical Governance Framework was conducted, and the report is included in the overall assessment of the organisation. The Healthscope Clinical Governance Program sets out the vision and strategies to always support safe and high care delivery by clearly articulating staff roles and responsibilities. PoWPH follows the CGP in line with the overarching clinical governance of the organisation. Discussions with senior clinical leaders within the hospital, proved evidence that they were all committed to providing a very high level of care and that they took their clinical safety and quality responsibilities very seriously. They reported their role in monitoring the outcomes of care and steps they may/had taken to investigate suboptimal results and act to improve them along with their care team, as with all Healthscope managed hospitals.	
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 provides a central repository for Healthscope National Policy and other related documents such as procedures and protocols. Local documentation also occurs that this specific for PoWPH. All the documents reviewed during the assessment along with interviews with the Executive Team and Senior Managers at PoWPH demonstrated how policy documents, procedures and protocols are managed to ensure they are comprehensive, effective, current, appropriately referenced and compliant with legislative and State requirements. All these documents had been made readily available to all staff and they were easily and readily accessible via the organisation's intranet. Compliance is monitored through incident reports and increasing trends influence the review and revision of specific documents. Most of these documents are reviewed every three years, but a risk management approach was taken when defining the scheduled revision with policies related to legislation being revised more frequently and/or in response to a change in that legislation, for example, OH&S.	
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	
PoWPH, not unlike all Healthscope Hospitals was able to demonstrate it uses an organisation wide quality improvement system based on the Healthscope Clinical Governance Framework. There were Healthscope and PoWPH documents that outlined the Safety and Quality Committee reporting structure, terms of reference and committee agendas and minutes for all the relevant clinical committees. This was backed up by discussions with staff and consumers during the assessment who confirmed this. As with all Healthscope Hospitals, staff confirmed they received information on quality and safety performance and that PoWPH actively supported this. Each ward/department had the same Safety and Quality Boards as present throughout Healthscope hospitals and these were all visible for staff, patients and consumers to view. Many indicators of performance and outcome data relevant to the area was on display for all to see. Staff could explain how outcome data and information were used to continually drive improvement within the ward/department. The assessment team also noted that actions arising from quality and safety reports in committee minutes as well as comments on the ward and department boards were used to identify areas for attention and local improvement.	
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	
PoWPH supplies well-timed reports on safety and quality systems and performance to the Board, the Executive, the Senior Management Team, the workforce, and consumers. Recently, the CRC had increased its frequency of reporting to the MAC, Executive and Quality and Safety Committee (QSC). Staff including the Chair of the MAC confirmed during interview how PoWPH manages and reports on their safety and quality system. Reporting is conducted through the minutes from the clinical committees and is undertaken through a range of appropriate reports perused during the assessment visit. The MAC Chair and two other MAC members interviewed during the assessment were able to provide confirmation of the reports they received relating to safety and quality. Staff, patients/families/carers and consumers had performance indicators relevant to their department displayed on their local Safety and Quality Boards.	
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	
The Executive, managers, and staff of the organisation were able to explain how risks are identified and managed. They also were able to express how identified risks can be influenced by concerns from staff, patients and carers. The Executive Leadership team gather information from a huge range of sources enabling them to inform, define and operationalise the risk management system. Risks are constantly reviewed and refined as needed to ensure the Risk Register remains effective in managing both corporate and clinical risks. The organisation's risk register was very large and very extensive with every conceivable clinical risk on the register. This must take much time and effort to constantly monitor each single risk. There is an opportunity to further refine the internal process to reduce the total number of clinical risks into more complete/holistic set of risks. Business continuity plans to support service delivery in the case of an emergency or disaster are also contained in the risk management system. The assessment team saw evidence that the system is actively managed, evaluated and improved as needed. Reports related to the management of risks are regularly provided to the governing body, management, staff, consumers and the community.	
Suggestion(s) for Improvement	
Consider reviewing the number of clinical risks on the Risk Register to group similar risks together to reduce the total number of risks, especially those that are very well managed.	
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	
Clinical leaders, managers and all staff are encouraged to report any incidents or "near misses" through the incident reporting system (RiskMan). This was confirmed by the assessment team following interviews with staff in all areas, viewing the RiskMan system including some submitted incident and incident reports for various committees within the organisation. When asked, patients (and their carers/significant others) reported that they felt empowered to raise concerns if they felt it was necessary. The Quality and Safety Team provide analysis and feedback to all key committees and to staff on incident reporting and trends identified as a part of this process. This trend analysis of incidents is utilised to foster the initiation of quality improvement activities and mitigation strategies are also reflected in the organisation's risk register. Information on the outcomes of incident investigations is reviewed at the individual incident (in all cases) and aggregate levels to ensure the system is functioning as intended and to inform improvements where indicated.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
PoWPH has established an open disclosure policy and program which is consistent with the Australian Open Disclosure Framework. The Quality and Safety Team monitors how, why and when open disclosure occurs, and records of open disclosure were viewed by the assessors. Clinical staff were able to articulate their role in open disclosure and felt supported in initiating and participating in open disclosure. The Medical Advisory Committee (MAC) oversees all issues related to 'morbidity and mortality' which always requires open disclosure to the patient and/or carer/family. This process is of the highest priority for this committee who strive to find the underlying causes of all adverse events wherever possible. This relates also to adverse events related to patients who form part of a clinical trial within PoWPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
The PoWPH has a variety of mechanisms to gather feedback from patients, consumers, families, and staff about the quality of care provided. Feedback from consumers and their family mainly is provided through the 'Qualtrics' platform that was launched and is fully implemented in this organisation. Feedback from staff is often provided during staff huddles and patient rounding. The organisation's Consumer Advisory Committee (CAC) is also a major source of feedback from consumers and the community at large. Feedback has also been sought from local Aboriginal Elders in relation to service provision for Aboriginal and Torres Strait Islander people. This action is undertaken particularly well in this organisation. Feedback is analysed and reported through the relevant safety and quality committees. Report findings are also displayed locally on the Safety and Quality Boards in all wards and departments. The assessment team found evidence in committee minutes reviewed during the assessment as well as during interviews with staff, patients, and consumers. Staff and management provided examples of improvements undertaken because of the feedback. One example was the 'You said, we did' Board which quoted suggestions from patients/carers and the response back to them of action undertaken. This was proudly presented at the entry to the ward, demonstrating their commitment to actively dealing with feedback from their consumers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	
The assessors were able to review the PoWPH's complaints management policy and processes. This policy and the embedded processes are regularly reviewed to ensure they remain contemporaneous. The complaints management system is organisation-wide, fully established, and provided good support for patients, carers and the workforce to report complaints. Documentation supported the fact that both staff and consumers are appropriately involved in the review of complaints, the great majority of which are resolved in a timely way. Feedback is provided to relevant committees within the governance structure, the workforce and consumers on the analysis of complaints. Where appropriate and possible, action is taken to ensure improvements are made both in response to individual complaints where indicated and based on identified trends. Emerging trends often will also inform the risk register.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
Assessors reviewed documents and held interviews with senior staff and management during the assessment that confirmed the organisation analyses the demographics of its patient population and the broader community to identify those patients who are at a higher risk of harm. This includes the number of patients/consumers who identify as of Aboriginal or Torres Strait Islander decent. This information is then used to create, support and inspire decisions on service delivery and facility design. It also helps with planning to identify how to best address the needs of these diverse and higher risk patient cohorts. A good example of this is the addition of Aboriginal and Torres Strait Islander paintings, flags, greetings and welcome signs to establish the hospital as a place that cares about closing the gap between Indigenous and non-indigenous patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Comments	
At PoWPH the medical record remains paper based and is made available to clinicians at the point of care. Due to the very small size of room within the Medical Records Department, only 5 days' worth of records are kept on site, although there is a priority arrangement with 'Iron Mountain', the secure medical record storage and retrieval company, which guarantees retrieval and made delivery available within 2 hours in an emergency. The healthcare record is organised in such a way as to support accurate, comprehensive, and timely documentation. Clinical staff were able to describe how they use the healthcare record to assessors and many records were reviewed by members of the assessment team. These paper-based healthcare records are maintained securely in a very compact department which complies with privacy legislation. The hospital ensures that regular medical documentation audits are undertaken, and reports are provided, to clinicians, departments, and key committees, with remedial activity undertaken where indicated. Paper-based and electronic records are cross-referenced to alert clinicians to their use.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
The MyHealth Record (MyHR) system was implemented during 2015/6 at all Healthscope hospitals including PoWPH. Event summaries (admission notifications) and Nursing Discharge Summaries are uploaded to MyHR with the patients consent. This is a highly automated process. Front office registration staff have had education on gaining consent for the upload of the information existing in WebPAS into MyHR. Education was provided to all relevant staff. The MyHR uptake for this information was high at PoWPH. PoWPH ensures that it adheres to standards that are externally tested to ensure the system that interact with MyHR comply with standards set in place by NEHTA. The requirements of Advisory 18/11 have been met.	
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	
PoWPH has actively progressed the event Summaries and Nursing Discharge Summaries being uploaded to patient MyHR with patient consent. There is an Healthscope Policy that describes the authorised access. PoWPH IT personnel have access for the purpose of monitoring the quality of the download of the event and discharge summaries that are uploaded into MyHR. The upload into MyHR is a highly automated process. The requirements of Advisory 18/11 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
The assessment team reviewed documentation detailing the orientation program provided to staff members. Staff were able to describe the orientation program and the inclusion of safety and quality responsibilities covered. All new staff attended the orientation program. Position descriptions and performance reviews also covered these expectations and responsibilities. Members of the Healthscope Board undergo a very rigid process that sits separately from PoWPH.	
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	
PoWPH had an action plan in place to address the issue of VMO mandatory education for those VMOs who only worked in the private sector. VMOs who work in the public sector must undertake this training as a condition of employment. PoWPH were actively ensuring that all VMOs were being risk assessed to ensure they had the mandatory training that was essential for the role they undertook within the hospital. For example, surgeons and surgical assistants required infection prevention and control education related to hand hygiene and aseptic technique but were not required to have Advanced Life Support (ALS) as that was not their primary role in this organisation. The assessment team encourages the efforts the Executive Team are making to provide excellence in patient safety and care.	
Suggestion(s) for Improvement	
It is suggested that the Executive and MAC continue to monitor compliance with best practice education of VMOs.	
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	
An Aboriginal and Torres Strait Islander Cultural Awareness program (Cultural Awareness and Sensitivity Training) is part of mandatory training for staff. The program has been reviewed by Healthscope Aboriginal advisors. PoWPH has implemented cultural awareness training in collaboration with the PoWHospital Randwick campus and current compliance sits at 98%. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
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	
Staff Performance Reviews are conducted annually for all staff. These performance reviews help to identify staff training needs and are used to provide the organisation with a 'Training Needs Analysis' and subsequent ongoing Education Plan. Staff were able to confirm with the assessors that they had undertaken their annual performance review and found the process helpful in guiding their development as a staff member. The performance review completion rate is monitored and current compliance rates are over 80%.	
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
PoWPH uses CGov to support the documentation and processing of Credentialing and defining the Scope of Clinical Practice for each registered clinician working within the organisation. Interviews with the Executive, the HR VMO representatives and members of the Medical Advisory Committee (MAC) confirmed that processes are in place to ensure that clinicians are working within the defined and agreed scope of clinical practice. The scope of practice for each clinician is consistent with the role delineation of the organisation. This scope of practice is reviewed in accordance with policy (initially within 6 months, then in 12 months, and if satisfactory every 2-3 years) and when required to accommodate new / altered procedures or technologies such as the use of robotics during surgery. Scope of clinical practice is provided for all AHPRA registered clinicians. The requirements of Advisory 18/12 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
Credentialing is overseen by the Hospital Executive and at least one HR representative. The Medical Advisory Committee (MAC) reviews and endorses the credentialing and scope of practice. All professions subject to professional registration requirements are monitored and checked on the AHPRA Data base by the relevant professional head. The credentialing processes are monitored and reviewed to ensure they remain appropriate and robust. Re-credentialing is undertaken one year after the first appointment for VMOs and surgical assistants and then five yearly unless there is a change in between. The requirements of Advisory 18/12 have been met as well as the NSQHS Standards Fact Sheet / Brochure Certification and Re-certification of practicing Colonoscopists.

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	
PoWPH staff interviewed by the assessors were able to articulate their roles and responsibilities for quality and safety. These are defined in position descriptions for staff employed by the organisation and in contractual arrangements for the provision of agency and locum staff. Orientation and onboarding include information for staff on these responsibilities. Quality and Safety Boards in ward and departments reinforced these responsibilities displaying many outcome indicators of the patient care in each area.	
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	
Clinicians at PoWPH are provided with appropriate supervision for their level of role and responsibility. This is supported by the organisational structure with the CEO and members of the Executive team and Medical Advisory Committee (MAC) available and able to intervene if clinically required. After-hours access to medical staff is provided by salaried medical officers who are available twenty-four hours a day. VMOs are always available after hours to provide advice or return to review their patients if required. This requirement is clearly set out in the Medical Services Regulations and is a condition of their appointment.	
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	
PoWPH provides clinicians with a range of decision support tools, best practice guidelines, care pathways and clinical care standards to support their clinical practice. Performance reviews provide an opportunity for clinical staff to request additional evidence-based documents. Staff did comment on the benefits of access to library services. PoWPH is compliant with Advisory 18/12(b) and ACSQHC Fact Sheet 11.	
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	
Clinical variation is monitored by analysing comparative clinical outcomes data (both internal and external) and results are used to inform individual and aggregate performance, support clinicians in actively participating in clinical reviews and to inform changes needed to minimise unwarranted clinical variation. Where clinical variation is identified a risk management approach is used to minimise harm from unwarranted variation. Clinical data reports from registries, HAC reports, as well as comparative indicator reports from ACHS and Healthscope are used to inform individual and aggregate performance. The organisation is compliant with the requirements of Advisory 18/12 (1.28a).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Comments	
A review of safety and quality documentation substantiated staff interviews and observations by the assessment team that the preventative and reparative maintenance of buildings, plant, equipment, utilities, devices and other infrastructure is undertaken to ensure that they are fit for purpose. Safety of the environment is considered in service planning, design and capital works. Staff were able to describe and demonstrate how to log a job for a maintenance issue and they reported responses were timely.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Comments	
PoWPH has undertaken a review to identify areas that have a high risk of unpredictable behaviours and has processes to ensure emerging risk areas can be appropriately identified. Strategies have been developed to ensure that people are treated in appropriate areas and risks associated with unpredictable behaviours are considered. Processes are in place to minimise the risk of harm to consumers and staff by unpredictable behaviours. Wherever possible, patients are provided with a quiet and secure environment, particularly if they are identified at high risk of cognitive impairment and/or confusion.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
PoWPH directional signage, both internally and externally is clear and fit for purpose given the unusual location within the Randwick Precinct. The assessment team were able to successfully navigate an unfamiliar environment.	
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	
Flexible visiting arrangements are in place broadly across the hospital. Patients and their carers/relatives reported satisfaction with visiting arrangements which were much more flexible under particular circumstances, especially if the patient was in a private room or under palliative care.	
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	
Partnership with the PoWHospital Randwick campus and with the Aboriginal Health Liaison Officers have assisted with the review of local environmental cultural practices. Local artworks and acknowledgement plaques are in place, and celebrations of Aboriginal and Torres Strait Islander events are planned. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
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	
PoWPH have implemented a range of policies and procedures to support the system for partnering with consumers. There is a PoWPH Consumer Advisory Committee which reports to the Executive Leadership Committee. Membership is low now, however there are plans to recruit shortly to support the large number of projects planned for the next year. Risk associated with consumer partnering in care and governance are included in the PoWPH Risk Register (Action1.10). There are a range of training topics on the PoWPH training plan to support consumer partnerships.	
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	
There are a range of quality improvement activities that have involved representatives of the Consumer Advisory Committee. Many of these projects were put on hold during the COVID-19 pandemic, however they will be commencing shortly and include, patient rounding, a review of the Cultural and Diversity Plan, a review of the Visitor Guidelines.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
PoWPH has many strategies to provide information on the Australian Charter of Healthcare Rights. The assessment team noticed many places where the poster of the Healthcare Charter of rights was clearly displayed, included on the website and information booklets as examples. Information is also available on the Australian Charter of Healthcare Rights in other languages. Access to qualified interpreters is also available.	
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	
There are processes to support informed consent. Consent is actively monitored as part of the POWP auditing framework. Compliance rates are approximately between 98-100%. There are systems to support patients to be fully informed with the provision of patient information sheets. These are routinely given during the pre-admission interview process. Financial consent process are presents and the organisation meets the ACSQHC's Advisory AS18/10: Informed financial 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	
Interviews with staff and examination of the organisation's documentation clearly demonstrated that there are processes in place to establish a patient's capacity to make decisions regarding their own care. There are also clear processes to be followed if a substitute decision-maker is required. PoWPH staff interviewed were able to articulate this process and provide the assessment team with access the relevant policy.	
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 review of documents and feedback from many of the patients interviewed by the assessment team clearly demonstrated that patients are actively involved in the planning of their care. The PoWPH bedside communication boards note patient goals and expectations. These were observed by the team to be updated daily on the communication boards.	
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 assessment team observed many excellent examples of where patients and carers were actively involved in their care. In addition, many patients interview confirmed this process was routine. Patient satisfaction surveys undertaken by the organisation support feedback to the assessment team that patients were satisfied with the level of engagement in their 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	
PoWPH has introduced a Cultural Diversity Plan to support the background information on cultural diversity at the hospital. Recognition of this work demonstrated that English is still the main language spoken (93.8%), non-indigenous admission 95.20% with a minimal number of people identifying as Aboriginal Torres Strait Island origin people admitted,1.03% (2022). However, POWPH has endeavoured to support the diversity of the patients attending their health services with consumers being provided a wide range of mechanisms. Significant action has been undertaken to align communications with the needs of the patients, carers, and their families.	
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	
Documentation reviewed by the assessment team, and interviews with consumer representatives confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs. Many brochures used by the organisation originated from the ACSQHC. Consumer representatives reported that they felt valued and could demonstrate where their feedback was acted upon. Of note is the planned redevelopment, a few years away however, the Executive have indicated a commitment to include consumers in this process.	
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	
At interview the consumers who participated on the Consumer Advisory Committee provided the assessment team information on the process that they took to review information. The committee has developed a checklist to support the review of brochure/pamphlets. Similarly at interview with many of the patients identified that they were very satisfied with the information provided to them and that they were very satisfied with the discharge planning process.	
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	
The assessment team were amazed with the level of positive feedback given by the members of the Consumer Advisory Committee interviewed. On discussion they confirmed their active role in the governance and evaluation of health care across this organisation. This is supported by the role consumers play on a range of key committees and groups including the Patient Care Review Committee.	
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	
Interviews with consumer representatives confirmed they felt supported in their roles. This includes orientation for consumer representatives and ongoing education where needed. One of the PoWPH Consumer participates in the general hospital orientation program. Consumer representatives reported being satisfied with the level of support provided to them and stated that the organisation was responsive to their information needs in interpreting data / reports / documents as examples.	
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	
PoWPH has progress to support active partnerships with Aboriginal and Torres Strait Islander people. There is a strong liaison with the PoW Randwick campus Aboriginal Health Liaison Officer who is available weekdays to support Aboriginal health issues of concern. In addition, PoWPH has identified local Aboriginal Communities and Elders and opinion leaders in the community, moving forward to support and enhance their actions and processes to meet the need of Aboriginal community. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
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	
One of the members of the Consumer Advisory Committee actively participates in PoWPH staff training.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
There are relevant and current infection control and antimicrobial stewardship policies that are easily accessible via the local L drive for staff to access. When infection risk is identified, it is included in clinical handover, documented on WebPas and communicated in the alert page. There are relevant procedures to ensure that staff were able to confidently operationalise the policies and procedures of the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02	
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks	
Comments	
The organisation is supported by the Infection Control Coordinator (ICC) as well as HICMR. Mandatory training of Infection Prevention and Control for clinicians is at 89% as of June 2023. HICMR Modules for other staff has completion rates that was high across the multiple modules ranging between 92% - 100%. All patients admitted to the hospital with infections are screened and identified at pre-admission or at the time of admission to hospital. There is a regular screening program in place for high-risk MRO patients in hospital for example in the Intensive Care Unit. The ongoing review of the incident with Mycobacterium chimera infection from heater cooler units is evidence that the organisation is actively monitoring and mitigating risks for patients. Antimicrobial Stewardship at the PoWPH is progressing along well. There is active engagement from HSP Pharmacies. The recent appointment of an Infectious Diseases physician will further enhance the AMS program. Staff have easy access to the Therapeutic Guidelines via the Healthscope Intranet (HInt). There is a clear pathway for escalation of care for patients on antimicrobials and for patients with significant microbiology results. Surgical prophylaxis is prominent in the theatre environment. Waste management continues to be challenging post COVID-19 pandemic. Clinical waste remains the biggest component of waste. The organisation is working towards reducing clinical waste by encouraging recycling where possible.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.03	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources	
Comments	
There is a regular schedule of audits (MARS) which staff are familiar with. Audit reports form part of the quality boards on each ward where rates of infections and hand hygiene are displayed. A quality improvement with project was undertaken regarding the high ceftriaxone use which has resulted in a marked reduction in its use. Recent audits targeted the surgical antibiotic prophylaxis of Orthopaedic cases and antimicrobial use of the cardiothoracic units. Processes are available for identification of restricted antibiotics through a traffic light system. Restricted antimicrobials are kept locked in a separate cabinet instead of the open imprest. These cases are routinely flagged to the ID physician for review on the twice weekly rounds. Results of audits and quality improvement projects are reported at the Antimicrobial Stewardship Committee as well as the Infection Control Committee, both of which are multidisciplinary in nature. These report to the Clinical Review and Patient Care Committees and up to the management and facilities management teams.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.04	
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
HPS pharmacies have brochures to advice consumers which covers antimicrobials for adults. Antimicrobials are also included in the Paediatric Discharge medicines brochure. The organisation uses consumer information from the Commission. There are links to the relevant consumer information which is easily available from Hint which staff were familiar with. Consumers see hand hygiene and infection rates on the quality board that is displayed on each ward. In addition, progress on improvement projects like Pericare to improve outcomes of UTI is clearly displayed. There are very few with multi-resistant organisms despite regular surveillance of patients' pre-surgery and routinely in the intensive care unit. The annual antibiogram from 2021 (2022 still pending at time of survey) showed few Staphylococcus aureus blood stream infections.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.05	
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Comments	
The organisation uses the Healthscope Corporate auditing tools (MARS). It collects data on healthcare related infections and antimicrobial use as well as other surveillance data including hand hygiene. A cardiothoracic care bundle was implemented to screen high risk cardiothoracic patients with the view of offering decolonisation to MSSA/MRSA preoperatively. There have been no recent line related infections in the organisation and rates of MRSA / VRE are low. The Antimicrobial Stewardship Program participates in the National Antibiotic Prescribing Survey (NAPS) as well as the Surgical National Antibiotic Prescribing Survey (SNAPS). The organisation is about to commence contributing to the National Antibiotic Use Surveillance Program (NAUSP) which will assist the organisation to compare and benchmark its usage with other similar services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.06	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws	
Comments	
Review of the organisation's processes and policies demonstrate consistency with the Australian guidelines for the Prevention and Control of Infection in Healthcare. Transmission based precautions charts are consistent with those published by the Commission and is used consistently throughout the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.07	
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions	
Comments	
Patients are asked on admission / in pre-admission clinic regarding infectious risks. These are then communicated throughout the patient journey in the organisation through WebPas. The organisation maintains compliance with Fit Testing for N95 masks. PPE training is freely available. Staff are required to undergo testing every 12 months. Transmission-based precautions are adhered to and upon discharge appropriate cleaning undertaken to ensure that the room is prepared for the next patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.08	
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care	
Comments	
Alerts generated from pre-admission / admission screening placed on WebPas is consistently reviewed and updated. Staff are aware of policy requirements for transmission-based precautions and were able to articulate the actions required in various situations. In addition to the majority of single rooms, documentation of the HVAC system of the organisation helps in planning where patients are accommodated to further reduce the COVID-19 risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.09	
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection	
Comments	
Transmission-based precautions form part of clinical handover of patients in this organisation. Alerts are on medical charts as well as on WebPas. Regular data is obtained from NSW MoH and is communicated to staff via newsletters. The Commission's patient information brochures are used to communicate to patients regarding their infectious risk / status and these were easily available on Hint as links which were active when checked. Infection information formed part of the nursing discharge from hospital which is then given to the patient as an adjunct to the medical discharge summary to the local medical officer for continuity of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance	
Comments	
The Hand Hygiene program is consistent with the National Hand Hygiene Initiative (NHHI). The organisation has two gold standard Hand Hygiene (HH) auditors with 15 validated auditors. Mandatory Hand Hygiene training is 94%. The latest NHHI data demonstrated an overall HH compliance rate of 92%. Visiting medical staff had a lower HH compliance rate (71 - 77%) between in the 2021-2022. This was addressed as an Action Plan. Since the implementation of minimum number of HH audits involving VMOs, there has been improvement noted with rates improving to 80% in 2023.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11	
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	
Procedures that require aseptic technique are identified. Aseptic Technique is mandatory training for clinical staff of the organisation and is recorded at a 90% completion rate.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
PIVCs are done by accredited staff. Staff are aware of where to look up necessary information on who to call for assistance with PIVC insertions. Current compliance with documentation of relevant information during PIVC insertion is at 80%. There is an ultrasound probe located in the Intensive Care Unit. It undergoes high level disinfection consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. There has been a new initiative in the last month to improve high level disinfection. The aim is to reduce harm to patients through helping ensure that the cleaning process is more accurate. The organisation has a fully documented process for the use of patient specific, reusable semi-critical and non-critical called the 'RMD project 2023' which is a staged approach to meet AS/NZS 4187:2014 requirements and ensures that reprocessing of semi critical RMDs (such as tourniquets) is embedded into everyday clinical practice. This was an excellent large body of work to ensure the safety associated with semi-critical and non-critical patient equipment and medical devices.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Comments	
There is an environmental cleaning policy with regular auditing. There is clear communication from the wards detailing whether a routine clean or a terminal clean is required. The call bell system in the organisation further helps with room identification, cleaning in progress and when rooms are ready for admission. There are processes in place for COVID-19 cleaning of the environment in the organisation. Auditing of cleaning forms part of the organisation's MARS audit schedule.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.14	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	
Comments	
There is a Product Review Committee within the organisation. All existing equipment is tagged. Maintenance is both a scheduled and responsive system. A logging system is available to staff for notification of equipment that needs to be repaired in a timely manner. BGIS is responsible for maintenance, repair and upgrade of building. There is a comprehensive water testing schedule including Legionella testing that occurs quarterly. The organisation has reviewed risks associated with COVID-19 by having a good understanding of the HVAC system to minimise risk of spread. Clean linen is appropriately stored in the clinical areas in closed cupboards. Dirty linen is transported via linen skips to the designated pick-up areas. Linen cleaning is contracted out by the organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients	
Comments	
Workforce immunisation requirements are in accordance with the current edition of the Australian Immunisation Handbook. Immunisation status is captured during the recruitment period and compliance is required prior to commencement of employment. There is currently no requirement for medical staff to provide evidence of immunity to other vaccine preventable infections with the exception of COVID-19 in accordance with State and National Guidelines. See 3.16 for further comments.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.16	
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection	
Comments	
A risk-based approach to managing infections in the workforces is applied to all employees. There is good and robust data kept of COVID-19 and other vaccine preventable infection vaccination rates for most healthcare workers. The current gap is in the medical staff. Recent cases of blood and body fluid exposures involved surgical assistants in theatre. It was noted that data on COVID-19 vaccination status has been incorporated to the current credentialing process for medical staff but not information on other vaccine preventable diseases. The accreditation team felt that vaccination status especially against Hepatitis B was useful to manage the risk of blood borne infections for staff and patients as per Action 3.16(c).	
Suggestion(s) for Improvement	
Healthscope Corporate consider incorporating vaccination status of other vaccine preventable diseases as part of credentialing in addition to COVID-19 vaccination for medical doctors.	
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
The organisation is well ahead of schedule with compliance to AS/NZS 4187:2014. The staff of the CSSD are well versed in their role in infection prevention. Instruments are reprocessed consistent with both the standards and manufacturer' guidelines. The Mycobacterium chimera infection that affected the organisation has increased and heightened awareness to traceability of equipment and patients. This incident remains on the Risk Register of organisation and is up to date. A high-risk scenario tested during the assessment reaffirmed the staff's ability to identify and manage the situation.

Rating	Applicable HSF IDs
Met	All

ACTION 3.18
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
Comments
The organisation's Antimicrobial Stewardship policy which details antimicrobial restrictions as well as the referral process to the infectious diseases physician is easily available on Hint. Therapeutic Guideline: Antibiotic eTG is easily located on the system. Clinicians were able to identify the location of policies and were able to describe how to access restricted antimicrobials that were kept in a separate locked cupboard. The organisation has noted comments from the assessment team regarding some elements within the Antimicrobial Stewardship Clinical Care Standard and have incorporated these into a revision of the Antimicrobial audit tool. The organisation currently participates in both NAPS and SNAPS.

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	
The organisation is going to commence submitting data to NAUSP from July 2023. This would be an important step towards ensuring that ongoing action can be taken to improve the use of antimicrobials through benchmarking. A quality improvement project was undertaken regarding the high ceftriaxone use which has resulted in a marked reduction in its use. Recent audits have targeted surgical antibiotic prophylaxis of orthopaedic cases and antimicrobial use of the cardiothoracic units.	
Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
The governance of medication management is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents and harm. The PoWPH has a contract with HPS pharmacy to provide pharmacy services 365 days a year. PoWPH Medication management is overseen by the Pharmacy Committee and reports through the governance structure of the organisation to staff and management. The organisation has a mandatory requirement for all relevant clinical staff to undertake Med+Safe education. The current compliance rate is 98%.	
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	
PoWPH monitors the effectiveness of the medication management system through incident reporting and uses the RiskMan reporting system. HPS pharmacy uses software called Clinpod to provide the discharge profile. The organisation undertakes regular monitoring of medication management including an order of the S8 medication register. Recent compliance was greater than 92%. A recent Mars audit identified 100% of entries on the medication chart were signed by the VMO. A recent quality improvement activity (QIA) was to improve the number of patients taking their own schedule 8 medications home. Since the implementation of the QIA the organisation has seen an improvement with the number of medications going home and consequently a reduction in patients own schedule S8 medications being destroyed. Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
PoWPH 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. Brochures provided to patients included Warfarin counselling and Clexane education. Patients interviewed, including consumers from the Consumer Advisory Committee, indicated that medication management was discussed with them and that they felt involved in the process and were able to understand the information provided.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
Scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians. Assessors observed several documents describing scope of practice for enrolled nurses and nursing/midwifery students.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
A best practice medication history (BPMH) is undertaken as soon as practicable and documented in the clinical record. The organisation has determined that this history would be undertaken for those patients identified as high risk such as those with polypharmacy. Compliance with completing the BPMH is currently not routinely monitored.	
Suggestion(s) for Improvement	
Undertake an audit to ascertain the compliance with completing the BPMH for those high-risk patients.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 4.07	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Comments	
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. Records reviewed by members of the assessment team confirmed their consisted use. Compliance with documenting medication related alerts is 87%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.08	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Comments	
Adverse drug reactions are reported through the incident management system and the organisation has a strong culture of reporting incidents and near misses. Medication related incidents are reviewed by the Pharmacy Committee and when relevant to the Anaesthetic Committee and finally the Patient Care Review Committee. The organisation has processes where a new allergy has been identified the anaesthetist writes to the patient and the GP ensuring that these parties are aware of the allergy. Where appropriate these patients are referred to allergy clinics such as the clinic at Royal North Shore Hospital.	
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. To date there have been two notifications in Q1 2023.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
The process for indicating the need for a medication review is evidence based and based on risk and clinical need. The document Comprehensive risk screening Part B details medication management risk such as over sixty-five, four or more medications, and difficulty in managing medications. Patients who have four or more risk factors and an admission greater than 48 hours will have a pharmacy medication plan. Clinicians may also refer to pharmacy based on their clinical assessment of the patient. Responsible clinicians were able to describe this process, how it is documented and how action taken in response to the review are followed though. Clinical documentation reviewed by assessors supported this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Patients reported being able to understand information about medications that was provided to them. Assessors were able to review HPS provided patient information including Clexane and Ferrinjet.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviews confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. A medication list is provided to patients and their GP on discharge.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to information and medication management support tools via pharmacy. Tools included eMIMS/TGA Guidelines and Drug injectable Book. Clinicians reported being able to readily access this information.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Comments	
Interviews with staff and a review of documents supported the assessors observation that high-risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. APINCH posters were observed in the medication rooms visited by assessors. Potassium Chloride ampoules are kept only on 5E CCU and ICU. There was one reported incident related to high-risk medications in Q1 2023.	
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	
PoWPH has a range of documents to assist with the management of comprehensive care primarily develop by the main Healthscope Comprehensive Care Working Party which has a PoWPH representative. The PoWPH Comprehensive Care Working Party oversees site base policies and procedures. These are accessible on the intranet and several staff interviewed were able to demonstrate the ease of access. Risks associated with the management of Comprehensive Care are recorded in the Risk Register (Action 1.10). There are a range or risk assessment tools utilised by the various disciplines and multidisciplinary team to use as the basis for the assessment of Comprehensive Care risks. There are a range of training modules for the staff to attend commencing at orientation and repeated as per the policy and mandatory training requirements. Staff compliance to this training exceeds over 80% to 100%.	
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 monitoring of Comprehensive Care is supported by the audit schedule. The outcomes of the schedules are monitored by the various teams, working groups and committees. On review of the outcome of these audits the assessment team were able to verify that there were no results that were out of the recognised compliance rate(s). The process of review noted follows the Baseline-Action-Measure process outlined within the Healthscope Clinical Governance Plan. If a low result is noted, then the team/committee will introduce an action and/or quality improvement plan measure to ensure an elevation of compliance. Several of these plans were reviewed for content and further discussion by the various teams to ensure that the quality implement processes as mentioned in Action 1.9/10 were in implemented. Following the various team meetings and interviews with various staff a significant number of quality improvement activities have been undertaken and planned to assist with Comprehensive Care. The overview of these projects was presented to the assessment team, and it was noted that most were displayed in quality boards and additional information given to staff. One staff development nurse has set up a WhatsApp Group to ensure that team members informed of activities, issues and policy changes.

Rating	Applicable HSF IDs
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Processes are in place to partner with patients in their care and associated decision-making as best suits the individual patient's needs. Feedback from the various patients interviewed highlighted that they felt fully involved in the planning and ongoing management of their care. One patient was really impressed with the ongoing management of the bedside communication boards, as this concept helped her identify who was caring for her and noted the discussion that she had has with the nurse on the plan for the day and outcome goals for her care.

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	
There are a range of policies and procedures to support the processes of communication for comprehensive care and planning for ongoing treatment. The health service is small and provided process for the assessment of patient. For example, in the pre-admission clinic to ensure that the patient is assessed then allocated to the area best suited to ensure they are provided care in the most appropriate setting. The referral process into PoWPH is primality by the patient's specialist with a range of administrative policies and procedure to ensure there is timely access to the required treatment.	
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	
Patient care is supported by a team of multidisciplinary care workers working together to identify the patients' goals and needs leading to discharge. Each member of the multidisciplinary team has a clear role and responsibility. The assessment team had an opportunity to observe the allied health team handover and the morning team meeting specifically to target discharge. The Journey Boards have been a great initiative to assist this team with planning ongoing and discharge need of the patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
As mentioned in Action 5.05 all the PoWPH clinicians work collaboratively to plan and deliver comprehensive care. These processes were supported following the review of clinical documentation including pathways of care, decision aides and examples of documents reviewed. Other examples included the witnessing of multi-disciplinary meetings and patient feedback.	
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	
PoWPH has a range of policies and processes are in place to screen and assess patients for risks aimed at minimising preventable harm. These were observed to be actively used within various aspect of clinical care observed by the assessment team. Routine audits are undertaken to ensure that the tools are completed according to policy as well as if necessarily repeated following episodes of deterioration. PoWPH meets the requirements of the ACSQHC's Advisory AS18/14 Comprehensive Care Standard Screening and assessment for risk of harm (Action 5.10).	
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	
Administration staff are required to ask patients on admission if they are of Aboriginal or Torres Strait Island origin. This information is entered into the Webpas patient administration system. This information is monitored on an annual basis current rate of 0.06% noted for 2.22. PoWPH meets the ACSQHC's Advisory AS18/04: Advice on Aboriginal and Torres Strait Islander specific actions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
PoWPH has a policy and protocol for end-of-life care and advanced care plan (ACP) that are consistent NSW Health directives.	
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	
PoWPH has a very comprehensive screening process which commences on admission and repeated as required (policy) and following deterioration. The depth of the risk assessment will depend on, for example, the patient's admission specialty, the clinical assessment on presentation, proposed procedure, and as mentioned these will be repeated when clinically indicated. There is screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound health outcomes. These tools all validated against best practice and accessible to staff on hard copy format. All the risk screening processes are subject to audit and reports are provided through the organisation's governance structure. Low compliance rates are reviewed as per the clinical governance processes. Audit results are presented to the community and staff with each department on the various quality improvement notice boards. The assessment team has limited time to review all clinical documentation however staff and patient interview verified that the process is clearly embedded into practice. PoWPH meets the requirements of the ACSQHC's Advisory AS18/14 Comprehensive Care Standard Screening and assessment for risk of harm (Action 5.10).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
The risk screening process assist PoWPH to assess the patients' conditions and apply the appropriate interventions according to the risk identified.	
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	
Any risks identified during the screening and assessment process are documented in the health record. Appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk. These processes are routinely monitored according to the PoWPH audit framework.	
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	
PoWPH has a range of guidelines, procedures, care plans and pathways to assist with guidance with the preparation of individualised patient care. Patient goals of care are identified for the plan of treatment. These are continually checked throughout the patient care journey. Referral processes are evident and monitored supported by the use of electronic patient boards, multidisciplinary meeting, team handovers and specialist rounds. PoWPH meets requirements of ACSQHC's Advisory AS18/15 Comprehensive Care Standard: Developing the comprehensive care plan.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
There is an end-of-life policy that is based on the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
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	
PoWPH has access to refer patients requiring palliative care to the PoW Randwick campus. Palliative Care patients are not routinely cared for at the PoWPH site.	
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	
PoWPH has a policy and protocols to request advanced care plans. When noted a copy is requested and kept in the medical record. A review of several medical records noted the process of recording of an advanced care directive or not. In any record with a noted recognition of an advanced care directive, the copy is kept in the front of the patient's medical record.	
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	
PoWPH provides supervision and support for staff providing end-of-life care. Support is provided by the relevant manager and where needed through referral to the Employee Assistance Program.	
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	
There is a process for the management of goals of care of patients end-of-life care these are received as per the policy.	
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	
Comments	
There is a policy and procedure to support shared decision-making about end-of-life with patients (or substitute decision-maker, care of family member). Support for decision making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
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 assessment team were very impressed with how PoWPH is providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management. The services are consistent with best practice guidelines and utilising contemporary treatments and dressings. All hospital acquired pressure injuries (rarely great than stage 2) are viewed by the Wound Care Consultant to verify stage, cause and treatment plan.	
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	
PoWPH clinicians providing care to patients at risk of developing, or with, a pressure injury conducts routine comprehensive skin inspections in accordance with best-practice time frames and frequency as noted in the polices. This practice is routinely audited and reported back to the workforce and consumers.	
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	
Patients, carers and families are provided with information about preventing pressure injuries through various medical process such as brochures, websites for example. The are a range of equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries.	
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	
PoWPH clinicians providing care to patients at risk of a fall that is consistent with the principles of best practice for the prevention and management of a hospital fall. Documents reviewed identified that there are processes for the identification of a patient at risk of a fall on admission, which is then repeated weekly with a process for review following deterioration. There is a post-fall management protocol.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
Information is available to patients, their carers / families about falls prevention and risk management strategies. This information is in a user-friendly format.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
Patients are assessed for nutritional needs and risk of malnutrition. Any high-risk patients are referred to the Dietitian for additional nutritional support. Special dietary plans are established for those who require them and referrals to a dietitian are made where risks are identified. The hospital provides patient with Total Parietal Nutrition as required. The assessment team observed evidence of screening and referral on review of records and interviews with staff confirmed their understanding of the process.	
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	
PoWPH provides nutritional support to patients based on their specific needs that are identified through risk screening. Patients who are at risk of malnutrition or who require assistance with eating and / or drinking are provided with assistance. The service has access to specialist dietetic support for those patients identified as at risk or with specific needs. Food and fluid intake is monitored and reported for those patients who are at risk of not having their nutritional needs met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Comments	
Cognition screening is undertaken on admission and as required throughout a patient's admission where clinically indicated. Evidence based policies and procedures support staff in developing appropriate management/care plans and these strategies are reviewed for effectiveness. This includes the use and monitoring of medications to ensure compliance with best practice standards. Screening rates are audited and reported through the various PoWPH governance committees. The organisation monitors the use of antipsychotic with only two episodes noted over the previous six months. The cognitive impairment protocol recommends antipsychotic avoidance. The organisation is compliant with the requirements of ACSQHC Fact Sheet 11 (5.29a) Applicability of Clinical Care Standards. PoWPH meets the requirements of the ACSQHC's Advisor AS22/01: Advice on implementing the updated Delirium Clinical Care Standard (released September 2021).	
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 various documentation reviewed by the assessment team demonstrated systems are in place to care for patients with cognitive impairment which should include cognitive screening, clinical assessment, established goals of care, assess for delirium, identify, and treat the causes of delirium. PoWPH is compliant with the requirements of the ACSQHC's Advisor AS22/01: Advice on implementing the updated Delirium Clinical Care Standard (released September 2021).	
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	
PoWPH has strategies and screening tools are in place to identify patients at risk of self-harm and / or suicide. There have been no registered incidents of patients at risk of self-harm of at risk or suicide.	
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 that have identified as developing issues of self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and referral service through referral to PoW Randwick campus. Staff were able to describe how they would access and use these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
PoWPH has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used.	
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	
PoWPH has strategies and processes in place to identify patients at risk of becoming aggressive including de-escalation strategies. The processes to manage aggression aim to minimise harm to patients, carers, families, staff and visitors and staff were able to describe how they collaborate with patients and others to implement these strategies effectively. Any incidents of aggression are registered into the RiskMan incident database and reported to the relevant PoWPH governance committee.	
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	
PoWPH has policies and processes are in place to govern and manage the use of both chemical and physical restraint and these includes alternative strategies to minimise the use of restraint.	
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		
There is not provision at PoWPH for seclusion as it is not a registered Mental Health Facility. Confirmation was sought from the ACSQHC to rate this action as 'Not Applicable' in accordance with ACSQHC's Advisory AS 18/01: Advice on not applicable actions.		
NA	All	**NA Comment:** There is not provision at PoWPH for seclusion as a result of the review of this Action. The assessment team agree that this Action should be a N/A rating according to the Commission's Advisory AS 18/01: Advice on not applicable actions. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** Yes

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	
Healthscope and local hospital policies and procedures are in place to support effective clinical communication including handover. There is a local PoWPH policy regarding Communicating for Safety which includes the ISBAR clinical handover tool. These policies identify risk management strategies and the training requirements / expectation of all staff in support of effective clinical communication. The governance of this standard is overseen by the Communicating for Safety working group. Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication. Training for communicating for safety includes correct site surgery which currently has a compliance rate of 96%. Additionally, there is training called “Relationship centred caring” which covers National standards 5 and 6. Current compliance rate is 76% with the organisation undertaking active measures to increase this compliance rate.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
Incidents relating to failure in clinical communication are reported through the incident management system and identified in patient feedback. Trends Identified through incidents drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover is monitored through feedback and audit. The Mars audit tool is utilised in all clinical areas. Audit tool results are shared with Clinicians and result in renewed focus in those clinical areas identified for improvement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation has policy that supports the engagement of patients, their carers and families in their own care and shared decision making. Patients participate in clinical handover and the assessors witnessed handover supporting this. Patients who were interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care. Patients interviewed stated that they and their carers were aware that they could also use the Patient Journey Boards to request any specific aspect of care they are either concerned about or wish to achieve. This means of communication was of particular focus in the paediatric ward.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes are in place to support appropriate identifiers are used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care / patient risk profile are identified. Documentation and clinical handovers viewed by the assessors supports the use of specified identifiers in these situations. ISBAR Posters were visible in many clinical areas.	
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	
Healthscope has policies that define the use of the three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity. Assessors witnessed this use when observing Surgical timeout and clinical handover between DoSS and the operating room and recovery to the clinical department.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 6.07	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient, and the clinicians involved in handover. Compliance with these requirements is audited and reported and the June 2023 current compliance rate is 100% in clinical areas such as 5East CCU and Paediatrics. Other areas that need to improve the compliance rate with clinical handover expectations undertake refresher education of their clinical staff. Clinical staff including allied health, nursing and medical officers could explain their respective roles in clinical handover the processes used to support this including the minimum information communicated at clinical handover. This supported the clinical handovers witnessed by members of the assessment team.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.08	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Comments	
The assessment team witnessed clinical handover that was structured using the ISBAR tool, and effectively engaged with patients, their carers and families in defining goals of care and decision making. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved, as necessary. Patients, carers and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learn shared and disseminated. Assessors noted that allied health type up their handover sheet. There is an opportunity to be more efficient in this process – please see the suggestion for improvement.	
Suggestion(s) for Improvement	
Allied health explores the use of the clinical database Webpas to generate an appropriate clinical handover sheet.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.09	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Comments	
The organisation has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Both patients and staff were able to describe to the assessors how this worked and how patients, their carers and families were involved when they wanted / needed to be. Additionally, multidisciplinary team meetings are undertaken to discuss long term patients during which alerts and risks are communicated. Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately. Assessors observed the Safety huddle in DoSS where the clinical lead shared any alerts and risks associated with the patients scheduled to go through the unit on that day.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. PoWPH has adopted the NSW health program called REACH for patient, family and/or carer escalation of care. Posters were sighted in patient rooms in the various clinical settings in the organisation. The mobile telephone number associated with REACH is detailed on all Patient Journey boards. Clinicians and patients / carers interviewed confirmed this and the assessors observed information available to support and facilitate this 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	
Clinical documentation reviewed by the assessors and handover meetings attended by assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information is recorded in the healthcare record. Members of the clinical team could describe this process.	
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	
Policies and procedures consistent with the organisation's safety and quality systems are in place for blood management and the management of associated risks. Organisational policies include "Jehovah Witness/ others refusing blood treatment therapy." Training is provided to eligible clinical staff with compliance reported at 93%. Relevant transport staff also undertake E-learning to ensure that there is an embedded understanding of the importance of transporting blood and blood products in a timely manner. Additionally, there are clinical area specific education such as the competency for ICU to process blood samples through the ROTEM machine. Recently, maternity staff participated in a scenario based educational day on managing an obstetric clinical haemorrhage.	
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 organisation monitors the blood management process in terms of blood and blood product utilisation, quality and safety and patient outcomes. Reports are provided to the Standard 7 Working Group and clinicians. PoWPH also participates in the Campus Transfusion Committee which involves Prince of Wales Public Hospital, the Royal Women's, Sydney Children's Hospital and the Eastern Heart Centre and PoWPH. This Campus Transfusion Committee allows the opportunity for each hospital/facility to share learnings from any clinical events. After each meeting, the representative from PoWPH provides feedback to the Director of nursing, quality manager and anaesthetic group. One quality improvement activity arose out of a clinical event where a severely anaemic patient went to the operating room. This incident resulted in changing of handover practices between DoSS and OR to include any recent significant blood results.	
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 organisation supports the engagement of consumers in care related to blood management including informed decision making. Patients who had received blood / blood products were available for interview and confirmed their engagement in informed consent. There are numerous consumer information brochures available for patients including "Receiving a Blood transfusion" which is available in forty different languages. Additionally, there is a brochure called "Yarning about Blood" specifically targeting Aboriginal and Torres Strait Islander people.	
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 organisations processes and policies support the clinically effective and efficient use of blood and blood products. Utilisation is monitored and action has been taken to minimise wastage and the inappropriate use of blood and blood products which is reported through the Blood Working Group and the Campus Transfusion Committee. The organisation uses the pre-admission process to identify surgical and maternity patients that may need assistance with optimising their own red cell mass, haemoglobin and iron stores. Through the pre-admission process the operating room booking staff are aware of patients having surgery where cell salvage can be optimised using the Cell Saver equipment.	
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 reviewed a limited number of transfusion records in the clinical records and found evidence to support the effective documentation of decision making such as consent and transfusion details such as routine observations undertaken during the administration of blood and blood products. This effective documentation is supported by regular audit of transfusion records. Where clinical areas have been identified as requiring improved documentation, an action plan has been developed and implemented.	
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	
Policies consistent with the national guidelines and national criteria for the prescription and administration of blood and blood products are in place and available to clinicians. There have been four incidents related to blood management between 1st January and 18th of June 2023. None of the incidents were considered as an adverse event. Each incident was investigated.	
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	
Policies and processes are in place to support compliant reporting of adverse events related to transfusions. These are monitored and reported through the Blood Management working group and the Campus Transfusion Committee. There has been no transfusion related adverse events so far in 2023.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
The organisation contributes to haemovigilance activities including transfusion reactions and incidents monitoring.	
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	
Blood and blood products are stored, distributed and managed in compliance with legislative and regulatory requirements and can be traced. Processes are monitored and reported through the blood working group. The 2023 MARS blood fridge audit found storage consistent with requirements. Any incidents related to inappropriate handling of blood or blood products is reported and managed through the incident management system.	
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	
Processes are in place to manage the availability of blood and blood products, eliminate wastage and respond to shortages. The use of blood and blood products is monitored and reported through governance reporting mechanisms. The utilisation of the ROTEM machine and associated logarithms has reduced blood wastage by ensuring that specific blood products are given to address patient deficits. Clinicians are kept informed of the latest information on blood and blood products through a newsletter called “Blood Drop” which is provided to clinicians every two months.	
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	
Policies and procedures are in place for recognising and responding to acute deterioration and staff were able to describe their role on such events. Risks and training needs are identified, and training records were made available to members of the assessment team. Current compliance for BLS is 96%. The organisation has collaborated with the Resident Medical Officers with current compliance at 80%, with 100% soon to be achieved. There is also greater than 95% compliance for specific clinical competences such as Neonatal and Advanced Neonatal Resuscitation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
Systems are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration and this is reported through the Clinical Deterioration Committee and to clinicians for the purposes of clinical review. In response to incidents related to clinical deterioration improvements have been made including the development of the flow chart to manage patients with Acute Mental Health deterioration. Additionally, work has been undertaken by the organisation to improve the management of neonatal hypoglycaemia which includes a revised express breast milk requirements and minimum volumes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Documents reviewed show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. For patient, family and or carer escalation of care the organisation uses the NSW health program called REACH. Posters are displayed in each of the patient rooms, the mobile number is on the patient journey board and the REACH information is available in different languages. The organisation provided details of two REACH calls which resulted in very swift action by conditions and avoided further clinical deterioration. This partnering with consumers process includes involving patients, meeting their information needs and shared decision making. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration. The assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital signs are monitored according to policy using the age-related track and trigger observation charts. A review of clinical documentation supported this as did regular auditing of clinical documentation. Through a recent audit process PoWPH had identified the need to improve compliance to the recording of the observations and has implemented an action plan to address this deficit. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation / intervention.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.05	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Comments	
Policies and procedures support staff in identifying acute deterioration in mental state including the risk or delirium. Assessment and care planning documentation reviewed by the assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration and / or delirium. One model used at PoWPH is that geriatricians work with surgeons to ensure that patients at risks are easily identifiable and early interventions implemented. There is a flow chart for patients experiencing acute mental health deterioration with access to the Psychiatric Emergency Care Centre and the ability to refer to their sister hospital the Sydney Clinic. Staff interviewed by assessors were able to detail this process. Clinical documentation is audited regularly and recent compliance with cognition screening is reported as 100%. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members as detailed in Standard 6. The requirements if Advisory AS 19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.06	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Comments	
The organisation monitors performance of the identification and management of acute physiological, mental status, pain and / or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the assessment team, including the process for escalation of care where needed. Should staff call a code black campus security come to assist. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. The requirements of Advisory AS 19/01 have been met (8.6 b, c, d, e).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers or families to directly escalate care. For patient, family and or carer escalation of care the organisation uses the NSW Health program called REACH. Posters are displayed in each of the patient rooms, the mobile number is on the patient journey board and the REACH information is available in different languages. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and the assessors were provided with documentation to support the evaluation of these processes which are reported through the Clinical Deterioration Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff were able to describe the systems in place to escalate care consistent with the organization's policy. The workforce including agency staff are provided with orientation to ensure effective utilisation of the recognition and response system. Reports provided to the assessment team and reported through the Clinical Deterioration Committee confirmed the effectiveness of these processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. Compliance with training is reported as 96% for ALS for required staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency. Training records were made available to the assessors with BLS compliance at 96% and ALS for required staff at 97%. The After-hours coordinators are required ALS competent. The organisation states that on the rare occasion when no one in the organisation has ALS support is available via “000” emergency response. Staff were able to describe the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. Staff articulated the flow chart for patients experiencing acute mental health deterioration. Staff have access to the Psychiatric Emergency Care Centre and the ability to refer to sister hospital the Sydney Clinic. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS 19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to members of the assessment team and the effectiveness of escalation of care processes are monitored through the committee. Staff spoke about the introduction of the Sepsis pathway in May 2022 which has supported clinical staff decision making and it has enabled patients to receive more rapid treatment.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil

NSQHS Standards Clinical Trials Assessment

Outcome Report

Prince of Wales Private Hospital

RANDWICK, NSW

Organisation Code: 120001
Health Service Organisation ID: Z1010011
ABN:85/006/405/152
Assessment Date: 27-29 June 2023

Contents

Clinical Trials Assessment Maturity Scorecard

Determine the mean maturity score:

$$\text{Mean maturity score} = \frac{\text{Total rating score for Clinical Governance Standard + Total rating score for Partnering with Consumers Standard}}{\text{Total number of actions}}$$

An example of calculations is provided at **Attachment 1**.

Maturity rating	Mean maturity score	Description
Established systems	3.0	The accreditation assessment team reviews evidence to demonstrate that all requirements of an action are in place and integrated within the operations of the health service organisation.
Growing systems	2.0–2.99	The accreditation assessment team reviews evidence to demonstrate that some of the requirements of an action are in place, with plans prepared to implement improvements to address identified gaps.
Initial systems	1.0–1.99	The evidence reviewed by the accreditation assessment team demonstrates that the requirements of the action are yet to be commenced or implemented.

Mean maturity score:

Total rating score for Clinical Governance Standard (54)	54
Total rating score for Partnering with Consumers Standard (27)	27
Total number of actions	27
Mean maturity	3
Overall maturity rating	**Established systems**

Sites for Assessment

Prince of Wales Private Hospital

Site	HSFID	Address	Visited	Mode
Prince of Wales Private Hospital Clinical Trials	101011CT	Barker Street RANDWICK NSW 2031 Australia	Yes	On Site

Standard 1 - Clinical Governance

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

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Suggestion(s) for Improvement	
Consider reviewing the number of clinical risks on the Risk Register to group similar risks together to reduce the total number of risks, especially those that are very well managed.	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Suggestion(s) for Improvement	
It is suggested that the Executive and MAC continue to monitor compliance with best practice education of VMOs.	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

ACTION 2.04	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials

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	
Rating	**Applicable HSF IDs**
Established systems	Prince of Wales Private Hospital Clinical Trials