NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Final Report

Lady Davidson Private Hospital

North Turramurra, NSW

Organisation Code: 110112
Health Service Facility ID: 100984
Assessment Date: 16-17 May 2023

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Lady Davidson Private Hospital underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 16/05/2023 to 17/05/2023. The NS2.1 OWA required two assessors for a period of two days. Lady Davidson Private Hospital is a private health service. Lady Davidson Private Hospital was last assessed between 27 – 29/8/2019.

Lady Davison Private Hospital is a 115-bed hospital located in beautiful grounds of the northern suburbs of Sydney that provides fast stream Rehabilitation, Medical and Palliative Care services to DVA entitled patients, and has a large Day Therapy Program/Outpatients Department. The hospital includes a Cancer Rehabilitation Program specially designed for people with a primary diagnosis of cancer post chemotherapy and radiotherapy, aimed at improving strength, mobility, and stamina. Its therapy and exercise facilities are clearly equipped to aim for world best practice for such rehabilitation.

The May assessment was conducted by two assessors over two days. All wards, departments and services were visited. During the assessment, the following methodologies were used: PICMORs, patient journeys, a high-risk scenario and proof of process journeys. There was extensive evidence reviewed through the quality management tool, eQuaMS, that supported access to policies, quality and improvement plans, minutes of committees and meetings, patient satisfaction surveys, and audit results. All documents reviewed contained up-to-date information.

Lady Davidson Private Hospital (LDPH) has benefited through low staff turnover, with many staff completing more than ten years of service. There is a calmness in the hospital that can only be achieved through a hospital with management and staff who are caring, confident and comfortable in their roles. The assessors saw evidence of the provision of a level of high quality and care.

All Standards that were assessed were rated as Met. One action (5.36) was rated as Not Applicable. The Met with Recommendation ratings from the previous assessment, were all completed and were closed by the assessors.

The LDPH Clinical Governance Plan and the Framework provides the plans and governance structure that ensures effective and efficient management of quality, safety and risk management for all its staff and patients. The Corporate HINT policy management structure that is complimented by local policies, and the newly implemented eQuaMS quality management system repository, provide a comprehensive and easily accessible source of all information needed throughout the organisation. Over time, this will become a rich and robust fount of information. At this point in time, staff are still adding to the information to be stored and becoming familiar with how to use it.

Addressing consumer engagement has been a major strength of LDPH and is an area that should be show-cased to others regarding how it can be done in a private hospital. With a small community living adjacent to the hospital that accommodates people who are keen to support the hospital, several people who have volunteered their services, conduct rounding of patients nominated by ward staff – to address their needs, and/or to simply be the visitor that some patients would not otherwise have the pleasure of having visit. This involvement is in addition to a very active Consumer Advisory Committee who assist the hospital in all of the consumer-engagement criteria required to be rated.

Infection Control is overseen by an enthusiastic leadership group, with thorough systems and processes in place. The training rates are high, and the audit results show high levels of staff understanding and compliance. The cleanliness and upkeep of Lady Davidson Hospital is of a high standard.

Medication Safety practices are well embedded into ward routines. The Medication Management Plan is well used and nurses perform medication administration carefully, involving patients in the process. Medication reviews are conducted consistently, and patients receive good education on their medicines.

The completion of a comprehensive care plan and assessment encompasses falls, pressure injuries, nutrition and cognitive impairment assessment and planning, and is a management tool that ensures that all elements of care are assessed on a regular basis. Discussions with patients and carers, confirmed the observations that the assessors made, that there is a high level of quality and safe care provided, and that all risks are managed appropriately, minimising any incidents experienced. Palliative care and pain management is supported, with the empathy that LDPH is known for.

All patients are identified using the approved three identifiers and ISBAR in communications. The introduction of a standardised format and printout for clinicians to use during bedside handovers and for safety huddles, has provided several benefits including that it is a brief but comprehensive overview of each patient's care, medications and associated risks. The daily Bed Management meeting is a further important communication between staff, that is a very effective part of the LDPH communicating for safety practice.

Blood and blood products are managed according to Healthscope processes and in line with the National Framework. Transfusion Care Pathways are audited, and blood storage is appropriate.

There are sound systems in place for the management of the deteriorating patient. There is a high rate of basic life support training completion, and Code Blue events are investigated and audited. The move towards having staff with Advanced Life Support training on site at all times further provides a level of safety for patients.

The excellent caring culture of LDPH has been further enhanced, and the future potential for growth strengthened by the appointment of a dynamic and knowledgeable senior clinical general manager to lead the organisation. He is well-supported by a core team of experienced clinical staff who have provided continuity of quality care for patients, and who are enthusiastically supporting their new general manager.

Summary of Results

Lady Davidson 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

Lady Davidson Private Hospital

Site	HSFID	Address	Visited
Lady Davidson Private Hospital	100984	434 Bobbin Head Road NTH TURRAMURRA NSW 2074	Yes

Standard 1 - Clinical Governance

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

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Comments	
A review was undertaken of the available documentation, consistent with the requirements of the ACSQHC Checklist for assessors (Reviewing information accessed and actioned by the Governing Body), supported by observations and interviews with key clinical governance leaders across the organisation, demonstrated that a culture of safety and quality improvement had been established. This was reinforced by the leadership team who set the organisation's strategic direction and ensured it is clearly communicated. The LDPH Clinical Governance Plan and the Framework describes the governance related roles and responsibilities across the services and supports staff to effectively partner with patients and families. A Committee Structure has been established to monitor the effectiveness of the clinical quality system through audit, data analysis and incident reports. A risk management approach underpins all aspects of clinical safety and quality.	
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	
Members of the Lady Davidson Executive were able to describe how the specific health needs of Aboriginal and Torres Strait Islander people are being addressed. Documentation reviewed by the assessors supported that the organisation has prioritised this and specifically on areas of inequity in service provision and outcomes for Aboriginal and Torres Strait Islander people. The organisation has consulted with an Aboriginal elder to determine areas of improvement that may be made to Lady Davidson to support a more welcoming environment. The planting of native plants at the front entrance to the hospital, and an area set aside as a meeting place for Aboriginal and Torres Strait Islander people, have resulted from communications with the Aboriginal elder. The organisation meets the requirements of Advisory AS18/04.	
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	
All staff in key clinical government leadership roles were able to describe the organisation's Clinical Governance Framework. Senior managers were able to demonstrate to the assessment team how the Framework is used, and how the effectiveness is monitored and reported, with changes made where indicated.	
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
Interviews with staff and managers were supported by observations and documentary evidence confirming that the organisation has strategies in place to monitor the effectiveness of quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people. There have only been three patients who are of an Aboriginal and/or Torres Strait Islander culture during the last 2-3 years. The organisation is monitoring the number of admissions of people who choose not to declare whether they are indigenous. This number has been reducing suggesting that there is a level of comfort of people to declare whether they are indigenous.

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
Documentation reviews including relevant committee minutes, along with interviews with senior managers and the Lady Davidson/Board confirmed that issues of safety and quality are key factors in the organisation's business decision making.

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	
A review of the documentation, reinforced by Assessor observations and interviews with staff, verified that they work within the governance framework. Staff confirmed that they understood their clinical safety and quality responsibilities and were able to articulate how the organisation monitors, reports and evaluates performance. Attendance at one of the daily Bed Management meetings by the assessors, demonstrated the regular and open communications that occur between the hospital executive and ward staff, ensuring that all are across the quality and safety aspects of the provision of care.	
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	
Documents reviewed, plus interviews with senior managers could demonstrate how policy documents, procedures and protocols are managed to ensure that they are current, comprehensive, effective, appropriately referenced and comply with legislation and regulations, along with State requirements. The Corporate platform, complimented by Lady Davidson specific policies, procedures and guidelines, ensures that a risk management approach is taken when defining the schedule revision of key documents. All policies checked by the assessors had been updated in accordance with their scheduled review dates.	
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
The organisation has a defined quality management system that produces performance and outcome data. Staff confirmed that they received information on quality and safety performance and that it is actively managed with minutes of meetings at all levels throughout the organisation supporting this. Outcome data and information is used to drive improvements through the clinical governance structure and is made available to staff, consumer representatives, the community and other stakeholders who are engaged in performance evaluation. The Quality and Safety Boards that are displayed throughout the hospital, display monthly statistics for: Patient Safety, Work Health and Safety, Education and Training, Infection Prevention and Control, Patient Experience and VMO Experience.

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
Senior staff confirmed during interviews how the organisation manages the safety and quality system. Reports are provided to the Board and senior management, the workforce, consumers and other stakeholders. Reporting is undertaken through a range of appropriate mechanisms, and in formats that are appropriate to the intended audiences. The implementation of the eQuaMs system has provided a repository of up-to-date quality, safety and management information that is easily accessible by staff, including minutes of meetings and audit reports.

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
Management and staff explained how risks are identified and managed and how this is influenced by staff, patients and carers. Information from a broad range of sources informs the Board and leadership teams to define and operationalise the risk management system. The system is reviewed and refined as needed to ensure it remains effective in managing both corporate and clinical risks. The risk management system includes business continuity plans to support service delivery in the case of an emergency or disaster. The assessors saw evidence that the system is actively managed, evaluated and improved as needed. Risk management reports are provided regularly to the governing body, management and staff.

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
Documents reviewed, plus interviews with staff, confirmed that all staff are encouraged to report any incidents or "near misses" through the incident reporting system, RiskMan. Patients and carers reported that they felt empowered to raise concerns. The clinical governance team provides analysis and feedback to all staff and key committees on incident reporting and trends. Trend analysis of incidents drives quality improvement activities, which are reflected in the organisation's risk register. Information on the outcomes of incident investigations is reviewed at the individual incident 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
The organisation has established an open disclosure program and policies, which are consistent with the Australian Open Disclosure Framework. There is a Corporate Policy and Procedure for Open Disclosure, which document the Principles and Procedures for Open Disclosure. The organisation monitors how, why and when open disclosure occurs, and records of open disclosure were viewed by the assessors. Staff were able to articulate their role in the open disclosure process and felt supported in initiating and participating in open disclosure. Compliance rates for completion of the Open Disclosure eLearning Program are at 98%.

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
LDPH uses a variety of mechanisms to seek and respond to feedback from patients, carers, families and staff about the quality of care provided by the organisation. Initial feedback may be given verbally, providing the opportunity for staff to address any concerns. The organisation has been fortunate to have consumers from the Consumer Advisory Committee conducts Rounding sessions with patients, and this has been a most valuable source of information for LDPH staff to respond to. Feedback is analysed, trended, reported and used to inform quality improvement strategies.

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 organisation's complaints management policy and processes. This demonstrated that an organisation-wide complaints management system was established, which supports patients, carers and the workforce to report complaints. Documentation shows that staff and consumers are appropriately involved in the review of complaints, which are resolved in a timely way. The organisation's KPIs ensure that responses are provided within the agreed timeframes. All KPIs have been achieved for the last six months. Feedback is provided to the governing body, the workforce and consumers on the analysis of complaints and action is taken to inform improvements both in response to individual complaints where indicated, and based on identified trends which 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
Documents reviewed, plus interviews with senior staff and management confirmed that 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 information is used to support decisions on service delivery and planning to identify how to best address their needs. The organisation will not admit patients who are at a high risk of harm.

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
The healthcare record is readily available to clinicians at the point of care and is organised in such a way as to support accurate, comprehensive, and timely documentation. Clinicians were able to describe how they use the healthcare record to assessors, and records were also reviewed by members of the assessment team. Healthcare records are maintained securely and comply with privacy legislation. Regular clinical documentation audits are undertaken, and reports are provided to clinicians, departments, and key committees, with remedial activity documented where it was required. 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
Healthscope as a national group, is actively progressing further integration of the clinical information in healthcare records with the My Health Record System. As opportunities arise the healthcare record is reviewed to inform this integration including the use of patients and provider identifiers and standard national terminologies. Since all Healthscope hospitals use the WebPAS electronic Patient Administration System, compliance with Advisory 18/11 is managed at a corporate level. Papers records continue to be used at LDPH. The record/folder for the patient while an inpatient in the hospital, is maintained at the bottom of the bed. This is integrated with the main record when the patient is discharged. The record is stored securely in the Medical Records Department. 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
The organisation is actively progressing further integration of clinical information in healthcare records with the My Health Record (MyHR) System. Information that is provided is compliant with legislative requirements and regular reviews support the accuracy and completeness of the information that is uploaded. 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 that detailed the orientation provided to members of the governing body, staff, contractors, locum and agency staff, students and volunteers. Training identified quality and safety roles and responsibilities, and contracts and position descriptions further supported this. Training records are maintained and were made available to the assessors, similarly a random review of contracts and personnel records by the assessment team confirmed the veracity of orientation. The Code of Conduct eLearning education completion showed a compliance rate of 95%, Hospital Orientation 93%, and WHS Emergency Management 83% for 237 staff.

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	
Interviews with clinical leaders confirmed that processes are in place to ensure that clinicians are working within the defined and agreed scope of clinical practice. Clinicians' scope of practice is consistent with the role delineation of the organisation. It is reviewed in accordance with policies and when required to accommodate new and/or altered procedures, or technologies.	
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	
A Healthscope Aboriginal and Torres Strait Islander Cultural Awareness program is part of the mandatory training for LDPH staff. The program and training records were reviewed by assessors and current attendance rates are high.	
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 for all staff that identify staff training needs. Education plans and training needs analysis are conducted in response to these reviews. Performance review completion is audited, and current compliance rates are 100%. Staff can articulate the performance management system and their role in the process.

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
Defining the scope of clinical practice is handled competently by the relevant LDPH professional groups, guided by Healthscope corporate policy and procedures consistent with National Standards. The process for defining scope is monitored locally and nationally, and regularly reviewed. Individual scope of practice is reviewed and revised in accordance with policies. LDPH does not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.

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, which is for 5 years, is overseen by a sub-committee of the LDPH Medical Advisory Committee (MAC) and is well established and managed with a supporting policy which is reviewed regularly. All professions, subject to professional registration requirements, are monitored and checked on the AHPRA database. The credentialing processes are monitored and regularly reviewed to ensure they remain robust. Recredentialling is undertaken according to the organisation's policies and procedures. LDPH does not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.

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
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.

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 are provided with adequate supervision according to their designated roles and responsibilities and this is supported by position descriptions and the organisation structure. Access to after-hour advice is provided through the LDPH on-call executive leadership team.	
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	
The organisation provides clinicians with access to a range of tools, best practice guidelines, care pathways and the clinical care standards to support their clinical practice. LDPH does not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.	
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. Assessors were able to verify these processes through interviews with staff during the Assessment. LDPH does not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.

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 and design. Involving consumers from the CAG to assess the environment has been a good initiative by LDPH.

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	
The organisation 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. All LDPH staff are required to complete the Management of Aggression training, and the use of de-escalation strategies training, as part of the scheduled annual mandatory training.	
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	
Directional signage internally and externally is clear and fit for purpose. Consumers from the CAG have reviewed LDPH signage and have made suggestions for improvements, which have been actioned by management. The assessment team was 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. This is particularly important for visitors to Palliative Care patients. Staff and patients reported satisfaction with the visiting arrangements.	
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	
LDPH demonstrates a welcoming environment and genuinely recognises the importance of the cultural beliefs and practices of the Aboriginal and Torres Strait Islander people. Specific examples include the consultation that has occurred with an indigenous Elder who has advised on the native plants for the area in front of the hospital, in the nomination of an area as a Meeting Place for Aboriginal and Torres Strait Islander people, the display of culturally appropriate flags in patient areas and in the display of artwork that has been provided by Aboriginal and Torres Strait islander people.	
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	
Interviews with staff and patients together with a review of policies and procedures supporting partnering with consumers show that the principles of safety and quality are applied when these documents are developed. Consumers are engaged in policy development, implementation and training. They assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation. Training is provided to staff, which shows a high level of attendance.	
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	
A review of documentation and interviews with staff and consumers confirmed that the organisation aims to improve partnerships with consumers at all levels. The assessment team observed how these strategies are monitored and how the organisation reports on partnering with consumers quarterly to the Consumer Advisory Committee.	
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	
A review of the health service demonstrated that the Charter of Rights is consistent with the Australian Charter of Healthcare Rights and is readily available throughout LDPH. Action is taken to ensure that the Charter of Rights can easily be accessed and is understood. Reminders of the importance of the Charter of Rights is displayed on walls throughout the hospital.	
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	
Interviews with staff indicated that they understood their responsibilities with respect to informed consent. The consent policy and processes comply with legislation, and reference best practice. A review of medical records supported that compliance with consent is occurring and that it is audited. The requirements of Advisory 18/10 have been met with respect to 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	
A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care, plus the process to be followed if a substitute decision-maker is required. Staff were able to articulate this process and their access to 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	
Interviews with patients and clinicians confirmed that staff work with patients, or a substitute decision-maker in shared decision making about their care planning, and the development of goals of care, when and where it is appropriate. The implementation of the Patient Care Boards in each patient's room has enabled regular updates of patient goals during the clinical handovers.	
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	
Staff and patients were able to describe to the assessors how patients are actively involved in their care. Patients and carers interviewed confirmed this, and satisfaction surveys undertaken by the organisation also support that patients are satisfied with the level of engagement in their care. Observations by the assessment team during clinical handovers supported that patients generally like to be involved in care discussions and decisions.	
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	
A review of information provided to consumers through a wide range of mechanisms demonstrated that significant action has been undertaken to align communications with the needs of the patients, carers and their families. The involvement by CAC members in ward Rounding has provided an invaluable input to ensuring that the needs of the patients are being documented and are met. The diversity of the local community has considered in the LDPH communications and information that is made available, reflecting the diversity. Including a consumer on the CAC who is involved in NDIS has assisted in addressing the requirements of this specialised group. Patient satisfaction with communications and information provided to them is included in satisfaction surveys and reported positively.	
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. Discussions by assessors with members of the CAC corroborated the extensive and comprehensive range of publications that benefit from consumer involvement.

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
Clinicians were able to articulate how they effectively partner with patients in their care whilst accessing services provided by the organisation, and how they work with patients to support their ongoing care needs. Observations by the assessment team during the bedside handovers reflected the benefits achieved from patients keen to be engaged. The documented patient journeys displayed in LDPH by people who have been treated at LDPH in an inpatient, outpatient or in the community setting, are evidence of the partnerships in care that exist between LDPH and patients for the different patient journeys. Patient satisfaction with the information provided to them is reported as high as is their satisfaction with discharge planning. Patients who were interviewed by assessors also supported that they felt information was provided to them in a manner and format they could understand.

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	
Interviews with members of the Consumer Advisory Committee confirmed their active roles 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. In seeking feedback on service delivery, the organisation engages various mechanisms that encourage input from a diverse range of consumers and from the broader community.	
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	
Documentation and interviews with consumer representatives confirmed that they felt supported in their roles. This includes orientation for consumer representatives and ongoing education where needed. 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 survey results, data and documents.	
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	
The organisation has pursued a range of activities to better partner with local Aboriginal and Torres Strait Islander communities, and to better understand and meet their specific and unique healthcare needs. Staff interviews and a review of documents confirmed that the organisation actively engages with Aboriginal and Torres Strait Islander communities and seeks their input into service planning and care.	
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	
Consumer representative and managers were able to explain how the organisation works with consumers to incorporate their views and experiences into training and education for the workforce. Staff interviewed were also able to provide examples of this training. Training records and programs were sighted by the assessment team that support this occurring.	
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	
Assessors reviewed infection control documents which were consistent with the safety and quality systems from the Clinical Governance Standard. These principles underpin the implementation of policies and procedures, risk management and determining training requirements for preventing and controlling healthcare associated infections, and antimicrobial stewardship. Staff were able to describe how they operationalise infection control related policies and procedures, how associated risks are managed and describe the training provided regarding antimicrobial stewardship and preventing and controlling healthcare-associated infections. The Infection Control working party comprises of a good cross section of staff who provide leadership within their local clinical areas.	
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
There is a schedule of auditing for Infection prevention and control systems. Audit results are provided to departments and wards and aggregate data is provided through the governance structure. Infection control and prevention and antimicrobial stewardship are discussed at relevant committee meetings which include consumer representatives and strategies are identified to improve performance where appropriate.

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
Patients are provided with clear information about infection control and any isolation requirements that may be relevant to them. Visitors are assisted to comply with requirements such as the use of PPE as relevant.

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	
The organisation monitors and collects data on healthcare related infections and antimicrobial use as well as broader infection control surveillance data. Reports on healthcare related infections and antimicrobial use are provided to clinicians and reported up through the governance structure. Consumers form part of the Quality Committee that reviews this data. Current data supports that infections rates are low and antibiotic use is appropriate.	
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 review of infection control documents indicates that processes consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for standard and transmission-based precautions are in place.	
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	
Procedures are available for implementing standard and transmission-based precautions and all staff (including non-clinical staff) are provided with education appropriate to their role. The 'Infection, Prevention and Control Care Plan' is a useful tool to support clinicians in the provision of appropriate care. There are simple strategies such as the use of the teacup with a tick at each patient room to provide housekeeping staff with visual signals about infectious status. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Facilities are designed to effectively manage infection risks and environmental management and cleaning practices are consistent with policy. There is a cleaning schedule for the carpets which are steam cleaned twice a year routinely, and in addition cleaned after the discharge of a patient who has had transmission-based precautions. The latest cleaning audit results show very high compliance, with an overall rate of 95%, up from the previous result of 83%. Contraindications exist for Hydrotherapy patients regarding infection prevention.	
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
Communication of a patient's infectious status is included at all transfer of care / handover points and compliance is monitored. Patients, carers, families and visitors are alerted to precautions that are required. The bed manager is aware of the infectious status of new patients awaiting transfer into Lady Davidson and the patients needs are met on arrival. All patients being transferred into Lady Davidson must have a COVID-19 test within 48 hours prior to transfer. Information on infectious status is also included on the discharge summary.

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
The requirements for single rooms and isolation procedures are discussed at the morning Bed Management meeting and the needs of infectious patients are met. The infectious status of all patients awaiting transfer to Lady Davidson is risk assessed and managed.

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	
There are good processes in place to review data and respond to community infections. Processes for aseptic technique are in place. Patients and family are provided with clear information about their infectious status, and family members are assisted with donning and doffing of PPE.	
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	
Training and assessment for the management of invasive devices are available to staff and align with the current legislation. Associated infection rates are monitored and reported. There is a hand hygiene program in place, and hand hygiene audit results show consistently high compliance with all moments. Audits are done in the Gyms as well as the Wards. The latest audit results were 91.6%.	
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	
Staff are appropriately trained in aseptic technique and competency and compliance is monitored. Current training rates for aseptic technique is 83%, with the aseptic technique practical training rate at 97%.	
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	
Training and assessment for the management of invasive devices are available to staff and align with the current legislation. Associated infection rates are monitored and reported. Staff competencies are in place.	
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
Healthscope and Lady Davidson has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen. Maintenance is both scheduled and responsive to local requirements. Cleaning procedures and schedules are in place with regular auditing and reports made available through the governance structure. Cleaning standards are consistently at or above benchmark targets. All staff have been trained in the appropriate use of specialised personal protective equipment (PPE) and compliance is monitored. A rigorous cleaning and maintenance program is in place for the hydrotherapy pool.

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 are procedures in place to clean equipment between uses. The Gym and Hydrotherapy areas are thoroughly cleaned every evening. Linen storage and handling is appropriate.

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
There is a comprehensive workforce immunisation program in place that complies with the Healthscope policy and national guidelines. Immunisation status is captured during the recruitment process. Overall staff vaccination compliance is 92%. At the time of assessment the flu vaccination rates of staff were low at 21% as the 2023 vaccination had not long been available. While it is not mandatory for staff to receive a flu vaccination they are actively encouraged to do so.

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
Processes are in place for the prevention and management of infections in the workforce, which are consistent with State Work Health and Safety regulations, and the Australian Guidelines for the Prevention and Control of Infection in Healthcare.

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	
There are processes in place for the appropriate cleaning of equipment and devices. Single use items are utilised.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.18	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement	
Comments	
The organisation has established an antimicrobial stewardship program that is guided by evidenced based policy. Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use. The organisation complies with the requirements of Advisory 18/08 and ACSQHC Fact Sheet 11 3(15D). There is a Spotlight Guide in place with specific approval requirements for antibiotics in the red and amber sections. Infectious Disease VMO approval is required for these antibiotics.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.19	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials	
Comments	
Documentation showed that the antimicrobial stewardship program included the review of antimicrobial prescribing and use and surveillance data on antimicrobial resistance. The program is evaluated, and performance is monitored with reports provided to clinicians and the governing body. Clinicians interviewed were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing. The requirements of the Advisory AS18/08 have been met.	
Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
The governance of medication management is defined by policies and procedures that apply a risk-based approach wo effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Comments	
The organisation monitors the effectiveness of the medication management system through incident reporting and routine audits. Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified. The results of the extensive NIMC audit show there are some areas for improvement indicated, such as the correct completion of patient ID on all pages, and continued support and education for doctors is ongoing.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation aims to involve patients in their care by providing appropriate information about medications and treatments, fostering shared decision making within the constraints of the person's legal status or capacity. Patient medications are reviewed by pharmacists and good education provided to patients on prior to discharge.	
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.	
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. There is some room for improvement with the documentation of medication reconciliation with a score of 70% achieved in the previous medication management plan audit.	
Suggestion(s) for Improvement	
It is suggested that real time education from the clinical pharmacist is provided to CMOs as they document and reconcile medication histories and the Medication Management Plan.	
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 discharge.	
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 in good.	
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 as a strong culture of reporting incidents and near misses. Medication error rates are low and these rates are publicly displayed in the Quality Boards in each ward.	
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. The clinical pharmacist reports any adverse reaction to the TGA.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
Medication reviews are completed for all patients by the clinical pharmacist, which are consistent with best practice. Medications are also reviewed at ward rounds. The Met with Recommendation given at the last assessment has now been completed and is closed.	
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 on specific medications is available to clinicians and appropriate to the patient population. Patients received good education on their medications, and blister packs are arranged on discharge as required.	
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	
Patients are provided with a current medications list on discharge. The medications are included in the discharge summaries for GPs with indications for new or altered medications provided.	
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	
There is access to medication support tools for clinician use.	
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	
Medication storage on the wards is appropriate. Refrigerators are monitored daily. The Vaccination Refrigerator is located behind the Wound Clinic area and that if there is a temperature excursion the alarm only sounds in that room. It was noted that the alarm will be added to the nurse alert system in the near future. Meanwhile hourly rounds are done and temperature excursions are correctly managed.	
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.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

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

ACTION 5.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Comments	
Comprehensive care is defined and monitored with a wide range of quality improvement activities being established to improve care including the installation of Quality Boards in each ward to assist in monitoring elements of patient episodes of care, for example, medication errors, falls and pressure injuries. The organisation uses feedback and outcomes data together with evidenced based practice to support improvements in care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe how they actively achieve this. The assessors observed discussions that occurred during clinical handover, between patients and staff regarding care decisions. Assessors interviewed patients, family and carers who could confirm their active participation and informed choices about their 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
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. The organisation operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processes for referral where needed. Clinicians with overall responsibility for a patient's care are identified, and the staff member accountable is clearly listed.

Rating	Applicable HSF IDs
Met	All

ACTION 5.05	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
Multidisciplinary care is well established, and the role of team members is well defined across the organisation. Staff from all professional groups and disciplines interviewed by the assessors were able to articulate how multidisciplinary care works across the organisation. The weekly case management meeting for patients clearly demonstrates the effectiveness of a multidisciplinary approach to care, and the preparedness of the patient for, and in the discharge planning process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Assessors witnessed respectful leadership and clinical engagement across LDPH. Clinicians were able to describe how they work collaboratively with other staff and with patients, to plan and deliver comprehensive care. This was supported by clinical documentation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
Comments
Processes are in place which commence during the pre-admission process, to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was sighted in clinical documentation. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The organisation is compliant with the requirements of Advisory AS18/14.

Rating	Applicable HSF IDs
Met	All

ACTION 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Comments
The organisation demonstrates processes are in place for identifying Aboriginal and Torres Strait Islander patients. This is recorded in the administrative and clinical information systems, and in the multidisciplinary comprehensive care plan. Staff were able to describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin. The organisation complies with Advisory AS18/04.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
Information and resources are available to support and assist patients to document end-of-life care plans. Where end-of-life care plans have been developed, they are filed in the patient's medical record, and the file is annotated accordingly.	
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	
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, physical risks and the social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the organisation's Patient Care Review Committee. A limited review of clinical documentation by the assessment team reinforced this. The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk. Any risks identified during the care of the patient are discussed during the daily Bed Management meeting, and during the clinical handovers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Comments
Clinicians and patients were able to describe the role patients, carers and families play in their care and in determining patient centred goals and how it aims to best meet their specific needs. A review of clinical documentation by the assessors reflected this and demonstrated that comprehensive care plan ensures that discharge planning is initiated as early as possible in the patient's journey. Members of the assessment team observed interactions between staff, patients, their carers and families that demonstrated this partnership in care and decision making. Multidisciplinary Care plans reflect contemporary evidence based best practice principles. The requirements of Advisory AS18/15 have been met.

Rating	Applicable HSF IDs
Met	All

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

Rating	Applicable HSF IDs
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
Processes to identify patients who are at end-of-life have been established. These are consistent with the processes outlined in the National Consensus Statement to ensure 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	
The organisation has access to specialist palliative care services and advice. Staff interviewed were aware of how to access these services. The LDPH has shown great empathy for palliative care patients and the preparation of the accommodation to accommodate patients receiving Palliative and/or end-of-life care.	
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	
Advance care plans are documented in the patient's healthcare record. Records are annotated appropriately, so that treating clinicians are aware. Clinicians interviewed were familiar with the process of identifying patients with an advance care plan, and ensuring care is provided in accordance with these plans.	
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	
Supervision and support for staff providing end-of-life care are available and staff are aware of how to access support services.	
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	
Goals of care for patients at end-of-life are expressed in the clinical record and established in partnership with patients, their carers and families. The planned goals are reviewed regularly, and any changes are documented in the clinical record.	
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	
The organisation supports shared decision making about end of like care with patients, their carers and families. This is backed by regular communications and documented in the clinical record. The assessors saw evidence of this in clinical documentation. 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	
LDPH utilises evidence-based policies for pressure injury prevention and wound management. These are reviewed on a regular basis and reported monthly. Pressure-injuries acquired during a patient journey in LDPH are infrequent. Patients are educated on how to avoid pressure injuries.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Skin inspections are conducted in accordance with policies. LDPH has a high level of compliance with the policies and a low incidence of pressure injuries.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is made available to patients, their carers and families about pressure injury prevention, as part of the admission process. This information is in a user-friendly format and staff were able to describe how they use it. Any patients who have a pressure injury when they are admitted to LDPH, are documented in the patient's clinical record. Equipment, products and devices are made available to manage any existing pressure injuries, and for the prevention of further 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	
Evidence based policies and procedures include risk assessment, prevention, harm minimisation and post-falls management. Compliance with undertaking falls risk assessments and falls management action plans is audited. Staff were able to describe strategies to minimise harm and clinical documentation reviewed by the assessment team supported that this is undertaken comprehensively. Incident data related to falls is analysed and reported through the organisation's governance structure. In a Rehab environment, falls are difficult to avoid, and falls prevention is a constant challenge. The assessment team saw evidence of a comprehensive program for falls prevention including educating patients on how to avoid falls. There are posters in all patient rooms reminding patients to wear shoes, and other action to be taken to avoid falls occurring.	
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 saw 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 and families about fall prevention and risk management strategies. This information is in an easy-to-follow format. This includes Facts on Falls, and the Top 11 Causes of Falls. There are many reminders throughout the hospital reminding patients, carers and their families of the risk of and how to avoid falls.	
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	
On admission, patients are risk-assessed for malnutrition and for nutritional needs. Special dietary plans are established for those who require them and referrals to the LDPH dietitian are made where risks are identified. Review of records confirmed the presence of screening and referrals. Staff interviewed 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
The organisation provides nutritional support to patients based on their specific needs that are identified through risk screening. Patients who are at risk of malnutrition or who require assistance with eating and / or drinking are provided with assistance. The organisation 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
Utilising the Montreal Cognitive Assessment tool, and the multidisciplinary Comprehensive Care Plan, cognition screening is undertaken on admission and reassessed, 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, where appropriate, the use and monitoring of medications to ensure compliance with best-practice standards. Screening rates are audited and reported through the LDPH governance structure. The organisation is compliant with the requirements of Advisory 18/12 (1.27b) and ACSQHC Fact Sheet 11 (5.29a).

Rating	Applicable HSF IDs
Met	All

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Comments	
Documentation reviewed shows systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken and compliance with screening is reported at the monthly departmental meetings. Staff were able to describe how the collaboration takes place with patients, carers and families in caring for patients with cognitive impairment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Strategies and screening tools are in place to identify patients at risk of self-harm. This process commences during the pre-admission and/or admission process. On identification of patients who may be at risk there are documented intervention strategies that staff were able to articulate. Alerts are documented in the patient's medical records. Patients who are considered as a high risk of self-harm, will not be admitted to the LDPH. Exclusion policies document the criteria that apply.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are to be used. Staff are trained to manage aggression, with online education made available to support the management of Behavioural challenges. Clinical Psychologists are available to assist and advise staff in the management of patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
The organisation has strategies and processes in place to identify patients at risk of becoming aggressive including de-escalation strategies. The processes to manage aggression aim to minimise harm to patients, carers, families, staff and visitors, and staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression, which are rare, are reported through the organisation's Patient Care Review 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	
LDPH uses no form of constraint, including physical or chemical restraint. Staff are trained to manage aggression and to avoid the need for any form 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	
The assessors supported the rating of Not Applicable. LDPH is not a gazetted hospital and uses no form of seclusion.	
Rating	**Applicable HSF IDs**
NA	All

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and the training requirements/expectations of all staff in support of effective clinical communication. Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communications.	
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 (RiskMan) and which are identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communications, including handover is monitored through feedback and audits.	
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
LDPH has policies that support the engagement of patients, their carers and families in their own care and in shared decision making. Patients are involved in clinical handovers and the assessors witnessed handover supporting this. The initiative by LDPHS to do only the afternoon handover at the bedside, has shown empathy for patients who have suggested that to conduct all handovers at the bedside could interrupt their rest time. Patients who may be engaged in considerable physical activity as part of their Rehab treatment regimen preferred for bedside handovers to occur once a day. Patients who were interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care.

Rating	Applicable HSF IDs
Met	All

ACTION 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Comments
Policies and processes are in place to support appropriate identifiers being used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care/patient risk profiles are identified. Documentation viewed by the assessors supports the use of specified identifiers in these situations.

Rating	Applicable HSF IDs
Met	All

ACTION 6.05	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
LDPH has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the assessors witnessed this when observing clinical handovers.	
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 observed the use of approved patient identifiers as noted in Action 6.5. As there is no surgery conducted at LDPH, there was no procedural time-out to be observed. However, as noted in Standard 4, the use of the three patient identifiers is used prior to medication being given to patients. A limited review of clinical documentation supported a high level of compliance with 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	
The introduction by LDPH in the use of a Clinical Handover report printed from WebPAS for all staff involved in the clinical handovers, has provided benefits and avoids any confusion with the patients being discussed. The Clinical handover documentation contains the required minimum content, relevant risks and needs of the patient, and the clinicians involved in handover are able to add brief details of importance. Compliance with these requirements is audited and reported and the current compliance rate is high. Staff could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover. Observation of clinical handovers by assessors confirmed the effectiveness of the clinical handover process.	
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. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, carers and family involved in decision making. The introduction of the Patient Care Boards that are now in every patient's room and are updated during the handover process, has provided further benefits to effective communications. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learned shared and disseminated.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients/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 confirmed compliance with the organisation's process to ensure complete, accurate and up to date information is recorded in the healthcare record. Patient records are maintained in the folder at the bottom of the patient's bed until the patient is discharged, when the information is filed in the patient's hard-copy medical record for secure storage in the Medical Records department. Members of the clinical team could describe this process. Comprehensive clinical documentation audits are conducted regularly, which the assessors saw achieved a high level of compliance. Any concerns with lower levels of compliance are addressed appropriately.	
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. Training is provided to eligible clinical staff with compliance reported at 92%. The number of blood and blood product transfusions done is low (around 20 per year) and a number of strategies have been implemented to support staff when transfusions are done. This includes the Blood Transfusion Pack found on each ward which has all the relevant documentation and patient education compiled in one place.

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. Transfusion Pathway audits are done routinely and improvements identified and acted on.

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. Consent is audited as a component of the Transfusion Pathway.	
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 indication for transfusion clearly identified.	
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 and transfusion details. This is supported by regular audit of transfusion records. Audit results indicate that there continue to be opportunities for improvement. Hourly vital signs were correctly recorded in only 50% of transfusions audited in 2022 and 2023, and the completion rates of the transfusions within four hours of the blood leaving the blood fridge are low.
Suggestion(s) for Improvement
Given the low number of transfusions performed at Lady Davidson it is suggested that the transfusion pathway audits are done more frequently and that the pathway requirements and the documentation audit results are featured in a case presentation style in-service for the clinicians who were in the care team for the patients receiving the transfusion.

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.

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.	
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 consistent with the national framework.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
Blood and blood products are stored, distributed and managed in compliance with legislative and regulatory requirements and are able to be traced. Processes are monitored and any incidents related to inappropriate handling of blood or blood products is reported and managed through the incident management system. The Blood fridge is audited regularly and audit results demonstrate high compliance.	
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.	
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 to recognising and responding to acute deterioration and staff were able to describe their role on such events. Mock training exercises are done routinely to consolidate staff knowledge and teamwork. Risks and training needs are identified, and training records show high levels of BLS training at 96%.	
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. Code Blue events are reported and reviewed to identify areas for improvement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Documents reviewed show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. This process includes involving patients, meeting their information needs and shared decision making.	
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 SAGO chart and a review of clinical documentation supported this as did regular auditing of clinical documentation. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation and 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 and management plans for patients with acute mental deterioration and / or delirium. Clinical documentation is audited regularly. 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. 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.

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 using the NSW REACH program. REACH posters were in ward areas and interviews with clinical staff and patients confirmed their knowledge of the REACH program.	
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.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff were able to describe the systems in place to escalate care consistent with the organisations policy. Code Blue mock training is done in the Gyms as well as in the wards.	
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 high, with 96% compliance of BLS education reported.	
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	
There is a clinician with Advanced Life Support training on site at all times. The organisation provides access to clinicians with advanced life support skills and competency. This has been a new initiative, and there is now a cohort of 22 ALS trained staff. Resuscitation Trolleys have been updated and have the relevant equipment required for advanced life support.	
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	
There is access to psychiatrists and psychologists and clinicians confirmed the process for timely referral to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. 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 acute hospitals via ambulance for patients who physically deteriorate. Staff were able to explain these processes to members of the assessment team.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil