NSQHS Standards 2nd Edition Assessment Healthscope - Gold Coast Private Hospital 101133

Accreditation Status	*Accredited*
Date(s) of Assessment	*05/09/2023 - 08/09/2023 (Final)*
Site	*14 Hill Street Southport QLD 4215*
Scope of certification	*For the provision of Acute Care, 24-hour Emergency Department , Intensive Care Unit, Cardiac and Thoracic Surgery, Coronary Care Unit, Cardiac Catheterisation, Children's Medicine and Surgery, Ear, Nose & Throat, Gastro-enterology, General Surgery, General Medicine, Medical Oncology, Gynaecology, Urology, Orthopaedics, Neurology, Plastic & reconstructive Surgery, Rehabilitation, Renal Medicine, Hospital in the Home, Respiratory Medicine, Maternity, Special Care and Birthing Suites. Support services include hotel services, education & training, administration and operational infrastructure.*

Details and Registration of the Health Service
Private Health Facilities Act 1999 for 339 beds, 26 Cardiac, 12 ICU, 9 Neonatal cots. Expiring 30/09/2023

Note: The information provided in this report is based on the information provided by the Health Service Organisation at the time of the accreditation assessment. Accreditation issued by Global-Mark does not guarantee the ongoing safety or quality of an organisation or its services or programs, or that legislative requirements are being met, or will be met.

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ABOUT THE COMMISSION

The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.
Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.
The Commission works in four priority areas:

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

THE AHSSQA SCHEME

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

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

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.
There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

RATING SCALE DEFINITION

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

Rating	Definition of rating
MET	All requirements 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 the additional implementation is required. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.
NOT MET	Part or all of the requirements of the action have not been met.
NOT APPLICABLE	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.
NOT ASSESSED	Actions that are not part of the current assessment process and therefore not reviewed.
For further information, see Fact Sheet 4: Rating scale for assessment.	

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.

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions not met or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed.
The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one off assessment with no remediation period. All actions must be met for the organisation to retain its accreditation.
For further information, see Fact Sheet 3: Repeat assessment of health service organisations.

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors and accrediting agencies on NSQHS Standards implementation, the National Safety and Quality Primary and Community Healthcare Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056 | Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre

ACCREDITING AGENCY

I, Kelly Gillen declare that Global-Mark Pty Ltd has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the National Safety and Quality Health Service / National Safety and Quality Primary and Community Healthcare Standard(s). This approval is current until 31/12/2024.

Under this authority, Global-Mark Pty Ltd is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Kelly Gillen declare that Global-Mark Pty Ltd has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

The following conflicts of interest were identified, and management of these conflicts have declared to the relevant regulator and the Australian Commission on Safety and Quality in Health Care:
NO REAL OR PERCEIVED CONFLICTS OF INTEREST IDENTIFIED
Further information can be found on the Factsheet 9: Managing conflicts of interest in accreditation

Is this the first assessment of this health service organisation by Global-Mark?	Yes
If yes, has the final report of the last assessment completed by the HSO been provided to Global-Mark?	Yes
Matters that arose during the assessment that may have impacted on the assessment outcome	Not Applicable

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Gold Coast Private Hospital
The outcome for this assessment is	Accredited
Date of accrediting agency determination	09/10/2023
Date health service organisation notified	09/10/2023
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

All actions rated not applicable complied with Advisory 18/01: Advice on not applicable actions. Not applicable actions below:

1.18, 5.36

Has the assessor verified actions were not applicable during the assessment	Yes
Have any actions not complying with Advisory 18/01 been approved by the Commission	No

Actions not complying with Advisory 18/01	Details of verification (Name and Date)
-	-

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	Yes A sample was reviewed with evidence of appropriate managment and closure.
Has there been any inspections/audits by regulators?	Yes Queensland Fire Service 16/11/22 - Compliant DIAS (Ultrasound and Diagnostic Radiology) Expiry date 12/4/2027 Gold Coast City Council FBFIX8019579 Expiry 31/8/24 Queensland Government Laser Safety Act Licence P005623416 Expiry date 8/3/2024

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements	Yes

Requirement	Assessment Outcome	Complies
Patient Episode	With verbal consent, there was an opportunity to observe various aspects of patient episodes during the assessment including: - Theatre suite including theatre team time out, gastroenterology team time out, stage 1 recovery care, clinical handover from anaesthetist and nursing staff from theatre to stage 1 recovery, handover from recovery room nurse to inpatient ward, patient identification and medication administration. - Day Surgery Unit including administration patient admission, nursing admission, anaesthetic nurse check prior to surgery, anaesthetic pre-op consultation, clinical handover from theatre to stage 1 recovery, clinical handover from stage 1 to stage 2 recovery and discharge to carer. - Pre-admission Clinic including patient education, screening and testing prior to surgery. Observation of the patient episodes enabled the assessors to verify that processes have been introduced for the requirements of NSQHSS edition 2 including (but not limited to) infection prevention and control practices; medication safety and administration; comprehensive care risk assessments, alerts and management; clinical communication including huddles, handover, patient identification and procedure matching; blood management processes; patient deterioration including emergency equipment and escalation. The assessors also observed patient related processes including: - Reprocessing of reusable medical devices including CSSD and Endoscopy. - Hospitality services including Catering and Cleaning. - Infection prevention and control processes and procedures A sample of medical records were also reviewed to further verify documentation of processes including clinical assessment prior to admission these include: UR 376536, UR 810532, UR 810205, UR 810187 and UR 553121. With verbal consent, there was an opportunity to observe various aspects of patient episodes and clinical processes during the assessment, including: · 0630 and 0700 Clinical Handover by registered nurses UR 811377, UR 707444, UR 521010, UR168363, UR377223, UR810989 and UR166920. · S4 and S8 medication checks and discharges - UR 807946 administration of Slow Release Tapentadol. Observation of the patient episodes enabled the assessors to verify that processes have been introduced for a number of the requirements of NSQHSS v2.1 including patient centred care, infection prevention and control practices, medication safety and administration, comprehensive care and risk assessment, identification of patient specific needs, clinical deterioration and emergency equipment, clinical communication including patient identification, procedure matching, handover involving patient, medical practitioners and clinical staff. Management of paediatric patients was also verified.	Yes

Requirement	Assessment Outcome	Complies
	The following medical records where reviewed to further verify documentation of processes: · UR 803308 – Palliative Care · UR 707444 – Palliative Care · UR 718470 – Immunotherapy - Day Infusion Centre · UR 811463 ED Admission · UR 811004 - Medical	
Consumer Interview	During the assessment, the assessors had an opportunity to speak with several patients during visits to the departments including an interview with a patient (UR 811043) in the pre-admission clinic receiving education and preparation for joint surgery and a patient (UR 811114) who had been admitted and was waiting for surgery. Both patients felt well informed, had opportunities to ask questions and was happy with the care they had received. There was an opportunity for assessors to speak with patients. Patient #175774 was undergoing her first admission to the Day Infusion Centre and found the doctors and nurses professional and caring. The admission process and paperwork were not difficult with all questions answered, and she appreciated having her daughters involved in the process for support. Patient #377223 expressed how much she liked the use of the board in their room. The patient specifically liked when the nurses wrote their names so she can use them and stated it was good for her goals of care as it provided a visual reminder. Patient #810989 and her partner stated they found the admission process online easy and the instructions and direction from the surgery “very simple and precise”. The patient stated that during her episode of care she was involved with identification checks, observed hand hygiene “every time” and all the questions asked were answered. The patient stated that the “standard of nursing was amazing, the room comfortable and nothing is an issue”. The partner stated that he and the family “love the progress app” which provided updates for when in OR and when they could visit. The patient stated it was “very organised”, she felt “very safe” and expressed how she “normally slept with earplugs and an eye mask” at home, but last didn’t require these as the night “was peaceful”.	Yes

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Donna Close (Lead Assessor)	Yes	Yes
Shelley Bustos (Assessor)	Yes	Yes
Susan Dunn (Assessor)	Yes	Yes
Bianca Woodley (Assessor)	Yes	Yes

Name and Designation	Opening	Closing
Daniele Doyle (CEO)	Yes	Yes
Denise Hartley (DON)	Yes	Yes
Linda Sawrey (Quality Manager)	Yes	Yes
Michelle Cestari (Research Manager)	Yes	Yes
Melissa Clune (Quality)	Yes	Yes
Kelly Harland (ADON)	Yes	Yes
Judy Ross (NUM Maternity)	No	Yes
John Petticrew (Housekeeping Services Manager)	Yes	Yes
Bernie Stark (NUM Recovery)	Yes	Yes
Louise Kay (Perioperative Services)	Yes	Yes
Stephanie Ashmore (Front Office Manager)	No	Yes
Chenoa Mullis (Health Information Manager)	No	Yes
Harsh Gondalya (Hospital Co-ordiantor)	No	Yes
Tenille Towie (NUM Ward 12)	No	Yes
Anne McLean (Quality Officer)	Yes	Yes
Sonja McDonald (Quality Officer)	Yes	Yes
Lucy Danaher (Quality Officer)	Yes	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	Paediatric service changes, water managment and gaps in leadership in perioperative serivces.

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO: - Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	Pharmacy - HPS Pharmacy QML - Pathology Hudsons - Cafeteria BGIS - Maintenance

List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of: - Sterilising - Laundry services - Food preparation - Theatre Services	Linen - Spotless/Ensign

Declared shared and contracted services were verified during this assessment	Yes
These agreements have been reviewed in the past three years	Yes
Consultants or Third Party participated in the assessment	NA

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Donna Close	A1011	Yes
Auditor	Bianca Woodley	A1943	Yes
Auditor	Shelley Bustos	A1923	Yes
Auditor	Susan Dunn	A1318	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

The assessment team recommends to Global-Mark Pty Ltd, based on the information provided, that Healthscope - Gold Coast Private Hospital be awarded accreditation. This has been confirmed by Global-Mark's Chief Executive Officer.

Executive Summary

Gold Coast Private is a 314 bed, 21 operating theatre facility offering the highest standard of clinical expertise and nursing care. The hospital is co-located with the Gold Coast University Hospital and Griffith University, forming a major part of the Health and Knowledge Precinct.
Gold Coast Private offers a range of services including a 24 hour Emergency Care Centre, Intensive Care Centre, Maternity Care Centre, Paediatric Care Centre as well as providing onsite imaging, pharmacy and pathology services.

Healthscope supports the facility, including a number of corporate documents available on the Intranet for staff to access. In addition, the facility uses the intranet for its local documents. Other software is utilised to assist including (but not limited to) RiskMan for risks, incidents and feedback, the Patient Safety Company software for VMO Credentialing and E-Learning software for education and training and eQuarms. There is an extensive committee meeting structure that assists with reporting and monitoring quality and safety data both at the local level and corporate levels of the organisation.
A recent review of service delivery has resulted in the rationalisation of paediatric services. The hospital will no longer undertaken overnight surgical admissions or any admission for sick children. There are currently sufficient services available on the Gold Coast for paediatrics.
The Queensland Private Health Regulation Unit is booked to visit the facilty on the 27/9/2023 for its routine inspection. The Medical Advisory Committee is co-chaired by an infectious disease physician and a surgeon. The hospital ensures the medical staff have a strong role in clinical governance and the credentialling of medical staff.
Consumer engagement in the facility is of an extremely high standard. The Consumer Representative made herself available to assist the assessment team.

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating
-	-	-	-

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating

DETAILED REPORT FOR STANDARDS ASSESSED

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
Evidence Reviewed
Healthscope promote a culture of safety and quality improvement within the organisation. Consumers and their carers are engaged in the process of reviewing safety and quality data. The highest level of governance in the organisation is the Healthscope Board. Locally the Medical Advisory Committee is the highest level of clinical governance. This committee is responsible or monitoring, reviewing and reporting on the organisations' quality performance. Locally, it is the Executive Team that are responsible for overseeing service provision. Gold Coast Private has a Clinical Service Plan FY 2023. This document includes a SWAT analysis and outlining of strategic goals. There are six Strategic Goals identified. This includes the hospital rationalising its services in order to grow appropriately in the current climate. Corporate services provided by Healthscope include Quality, IT, Legal, operations and People and Culture (including WH&S). There is a local organisational chart with reporting to the General Manager. There is a Perioperative Services Manager, Assistant Director of Nursing and Quality Manager who report in to the DON, The Hotel Services Manager , Director of Finance, and MAC report in to the General Manager
Rating
Met
Findings
-

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
Evidence Reviewed
The Governing Body of Healthscope has approved a Reconciliation Action plan for ATSI clients. The Reconciliation journey for Healthscope commenced in 2011 and continues today. Acknowledgment of Country is noted in the local Gold Coast ATSI Engagement plan. Cultural Diversity, Sensitivity and Responsiveness Policy informs staff how to deal with the needs of Aboriginal and Torres Strait Islander (ATSI) patients and their carers and families, in addition to the evidence provided demonstrated local community input about the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.
Rating
Met
Findings
-

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
Evidence Reviewed
There is a Clinical Governance Plan 2022-2023 which references the ACSQHC National Model of Clinical Governance. Policy is reviewed at clinical service level in the hospital. Information from Corporate clinical committees to ensure the site requirements are captured. The data collection processes in the hospital include data sets for ACHS and Healthscope. Multiple collections are in use and include but are not limited to gastroenterology, obstetrics, day stay, oncology and orthopaedics.
Rating
Met
Findings
-

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
Evidence Reviewed
Strategies for ASTI engagement are updated every two years. There was a delay to the updated 2023-2025 plan as Karen Mundine from Reconciliation Australia was bombarded with plans to endorse and it has taken longer than expected. The National Patient Experience Manager is responsible for updating the RAP. Key changes include increasing staff awareness of cultural values and beliefs, Appropriateness of care policy, Acknowledgement of Country Policy, NAIDOC week dates were reviewed and an organisation-wide focus on embedding stakeholders to self identify.
Rating
Met
Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
Gold Coast Private Hospital uses it clinical governance framework to ensure organisation-wide awareness of safety and quality data. The following elements were verified during the assessment. State Licencing Clinical Indicator Reporting and Benchmarking Patient Satisfaction Survey Risk register and Risk Management System Credentialing and scope of practice process for all VMO's Nurses and VMO's registration with AHPRA Staff described the processes for the clinical Review Committee Activities. The Minutes of the meeting held on the 14th August 2023 included discussion of Coroner's Case requests, ongoing critical service reviews, Health Ombudsman Complaints, Committee reports, including a fall in OR. AMS, transfer out due to inappropriate behaviour and updates on previous reviews.
Rating
Met

Findings
-

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
Evidence Reviewed
Clinicians are provided with position/job descriptions. Each contains a reference to the safety and quality systems in the organisation. The following elements were verified during the assessment. Each description describes the capabilities for success. These include service excellence, communication, safety, advocacy, managing work, earning trust, valuing differences, and collaborating. Dedicated roles and position descriptions for the following: Administration Manager Hospital General Manager and Director of Nursing Assistant in Nursing Enrolled Nurse Peri-operative Service Orientation programme for staff Orientation program for VMO E115 V15 06/2023 Performance appraisal review system Internal audits and associated corrective action plans
Rating
Met
Findings
-

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
Evidence Reviewed
Policies and procedures are in place to support ongoing review and maintenance of the information available to staff. The reviews are in response to updated clinical care standards, changes in regulation or the scope of service of the facility Legislation and regulatory instruments are included in the policy suite. Staff describe the overall responsibility for policy review sits with Corporate Staff in conjunction with the local Executive Team. Staff access the policies and procedures via the Intranet, Hint Program.
Rating
Met
Findings
-

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
Evidence Reviewed
The organisation maintains a quality improvement program by identifying areas for improvement from multiple sources in the company. Inputs to the process include but are not limited to the incident management and reporting system, internal audit program, patient, staff and doctor feedback and clinical indicator reporting. Outputs include reviews of the risk register, continuous improvement suggestions and key performance indicator reporting to craft groups, Healthscope, staff, patients, and the committee structure in the organisation. This is extremely well done. The CEO, MAC Chair and DON all described their visibility of data across the Gold Coast Private Hospital landscape. There is a National Directors of Nursing Forum that reviews infection control, clinical risk and governance processes. the meetings was held on the 21/7/23. The Executive Report on Quality and Safety for July 2023 was

provided for review. Data included KPI reports for Hospital Acquired Complications HAC, Patient experience PEX and Net Promoter Scores NPS. Data is compared to the previous year. The Report expands on the big picture data with commentary on the risk adjusted peer comparisons. Data includes pressure injury, 0.01, Falls resulting in fracture or intracranial injury 0.03, Healthcare associated infection 0.43, Respiratory complications 0.09, Venous thromboembolism 0.06, renal failure 0.01, GI Bleeding 0.03, Medication complications 0.03, delirium 0.21, incontinence 0.01, endocrine complications 0.05, cardiac complications 0.22, Third and 4th degree tears 1.57 and neonatal birth trauma 0.61%. Patient experience is running at 85.8% lower than the desirable rate of >87%

Rating

Met

Findings

-

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

Evidence Reviewed

Reports are provided to the governing body via the committee structure at regular intervals. The Governing body is noted as Executive Leadership Team in the facility, and the Healthscope Board at the corporate level. The workforce are provided with reports via multiple means. The Nurse Unit Managers describe regular communication with their teams.

Consumers are included via the Consumer Representative and her attendance at meetings across the hospital. These measures are in keeping with the clinical governance framework documents as outlined in 1.03

Rating

Met

Findings

-

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
Evidence Reviewed
There is an organisational risk register for the facility that is maintained in the RiskMan software. There are The register is proactive and based on clinical risks. controls are listed and a residual risk score provided. Examples of risks include but are not limited to: #17656 Absconding Patients #17603 Blood Safety #17588 MET Calls #17661 VMO not competent in BLS #19045 Failure to recognise Cognitive Impairment #17655 Failure of Clinical Handover #19028 Inadequate storge or disposal of medication Risks are reported to the highest level of governance via the Executive Leadership Team The workforce via the NUMs Consumers are made aware of the risks in the The facility has ensure emergencies and disasters are described and controlled via the Business Continuity Plan 05/2023. The Plan includes Cyber events, pandemics, natural disaster, human threats, supply chain disruption, power outage, water supply failure, sewerage failure, telecommunication failure, nurse call system failure, air conditioning failure, lift failure, medical gas failure, food services disruption, CSSD disruption, KRONOS outage and WebPAS outage.
Rating
Met
Findings
-

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
Evidence Reviewed
The Incident Management Policy 2.13 is included in the overarching Healthscope suite of documents. The policy mandates entry of incidents into RiskMan software. The CEO and DON confirmed they have visibility over the incidents. The DON sees all, the CEO only sees high risk incidents. All must be entered within 24 hours. Data is presented in a large variety of means. An overarching shared learning report is produced per quarter. The Q1 2023 report notes the trending of all HACs and improvements instituted as a result. This data is presented on the HINT intranet site. A review of RiskMan included the following entries: #2088986 14/7/23 Post partum haemorrhage - OR #2089632 19/7/23 Transfusion reaction - medical oncology The RiskMan report for July 2023 contained 80 clinical deteriorations. When discussed with the staff, it was clear that the culture of calling for assistance via MET is very strong at the facility. There are 56 reports of infections and 26 behavioural incidents. The overall reporting culture is very strong in the facility. There is clear accountability for safety and quality exhibited by the senior leadership team. The CEO, DON, ADON and MAC Chair use information from the reporting of incidents to improve the risk management system.
Rating
Met
Findings
-

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
Evidence Reviewed
Open Disclosure is referenced in the organisational policy 2.30 08/2020. Open disclosure is described in line with the Australian Open Disclosure Framework (2013 ACQHC) Evidence of open disclosure occurring through the facility. Policies are in place that adhere to the principles and processes outlined in the Australian Open Disclosure Framework. The consulting medical practitioner is responsible for disclosure and it is to be documented in the RiskMan entry. The process was confirmed for patient #745936 in RiskMan #2057832
Rating
Met
Findings
-

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
Evidence Reviewed
Patient experience is monitored by several means. The main tool is Qualtrics Software that generates a net promoter score. This is publicised at ward level on public notice boards, by each NUM at the twice daily NUM Meeting with the DON and ADON. This was attended by the assessment team, who were able to verify the communication of key information from the Nurse Unit Managers to the Executive. The Consumer Representative monitors feedback by visiting patients two day per week and journalling the responses. This is fed back to the DON and quality team. The Consumer Representative also reviews complaints as a component of her committee member roles. She sits on the Quality and Risk committee and reviews the complaints and feedback. She also attends the Heads of Department Meetings. Minutes from 24/8/23 and 20/7/23 were sighted and verified her attendance.

Rating
Met
Findings
-

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
Evidence Reviewed
Complaints are received via several means. Complaints management process is described in the Corporate Complaints Management Policy and Procedure 1.08. Formal complaints logged in the RiskMan software program Feedback log is kept for all complaints and compliments and can be sorted per department. Complaints are reported through multiple Committees. Consumers review complaints via the Quality and Safety committee. Department NUMs are responsible for the complaints in their areas. Generally the rounding process tends to capture issues prior to them escalating to a complaint. The Consumer Report will also capture these issues in her visiting time with patients. Staff review complaints at the department level with their managers. A random selection were reviewed as follows: #71684 20/7/23 Missed appointment due to parking - allied health #71642 10/7/23 No information at discharge - emergency department #71636 3/7/23 Husband not happy about early discharge of wife on a Sunday afternoon - Ward 1 #71535 3/7/23 Phone call re terrible food and overall dreadful stay - Ward 8

All complaints demonstrated follow up, action and closure. Many of the complaints reviewed were resolved with an apology. The NUMs present their timelines for addressing complaints as a KPI discussion at their Round Table meetings held each quarter.

The handling of complaints follows policy and can be an input into safety and quality improvement systems.

Rating

Met

Findings

-

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

Evidence Reviewed

The facility utilises information from their patient information software system and census data to identify the diversity of its consumers.

The organisation accepts patients

Interpreters are used when necessary and at times the use of family members for interpreting was raised by staff during interviews with assessors.

Patients are identified on admission if they are ATSI – included in Admission documentation

Hospital risk register which covers patient safety and quality risks.

Access to interpreter services and associated policy

Rating

Met

Findings

-

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

Evidence Reviewed

Medical Records policies include information on retention and disposal in accordance with state based guidelines and regulation.

Medical records were sampled at the point of care and included consent, demographic data, RMD traceability, national inpatient medication charts, observation and response charts, discharge summaries, evidence of clinical handover, operative or medical notes as applicable, assessment data, clinical pathways and evidence of regular review and assessment.

Corporate Medical Record Documentation Policy 2.39 11/19 notes the obligation to comply with AS2828.

Retention and Disposal of Health Information 2.21 05/22 notes the minimum period of retention of medical records is 7 years.

Records sent off site for storage, the room used for on site storage is temperature and humidity monitored and is secure. The medical records is in hard copy and has a traceability number attached to each file.

Computers are password protected.

Qld Legislation is referenced in the policy suite. Instruments include the Information Management Standards V5 Private Health Facilities Act 1999 section 12, Private Health Facilities Act 1999 (Qld), Health Sector (Clinical Records) Retention and Disposal Schedule QDAN 683v1 and the (Health Drugs and Poisons) Regulation 1996 (Qld)

Rating

Met

Findings

-

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

Evidence Reviewed
Progress towards meeting the requirements of MHR are well underway. Three senior staff have been designated on the PRODA portal. Nursing Discharge Summaries are available electronically. Gap Analysis sighted with sufficient actively to rate the indicator as Met.
Rating
Met
Findings
-

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
Evidence Reviewed
My Health Record is currently not in use by the facility. This action is not applicable as per Advisory 18/11.
Rating
Not Applicable
Findings
-

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

Evidence Reviewed
Clinical Bylaws are available to the VMO. The current version was adopted on the 1/7/2018. Medical Practitioners must sign to acknowledge the receipt and understanding of the Bylaws. There are over 1500 VMO credentialled at the facility. Each new VMO is required to complete an orientation package. This includes open disclosure, hand hygiene, BLS, PIVC insertion and Fire safety
Rating
Met
Findings
-

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
Evidence Reviewed
Training is facilitated by the requirements of each staff members role. A training and competence needs analysis is available. The program include quality and safety elements as outlined in the applicable NSQHSS. VMO are included in the training program and are required to complete the stated requirements. Catering Staff were sampled to confirm Ecolab certification training (IS, SB & AL). Training rates are monitored by hospital and by department. As at September 2023 ANTT 98%, BLS 93%, Blood Safe 96%, PPE Assessment 97%, Hand Hygiene 99%, Manual Handling 91%, Admin Manual Handling 91%, Manual Handling non-clinical 92%, Donning and Doffing 93%, Medsafe 82% and fit testing 76%. There are 31 Departments with individual compliance rates monitored and reported on by the Department heads.
Rating
Met
Findings
-

Action 1.21
The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Evidence Reviewed
Staff are required to complete education on ATSI clients in order to demonstrate cultural competence. Compliance is monitored by ward/department or overall by Hospital. Currently as at September 2023 the module has changed over but previous to this compliance for the 1400 staff was 93%
Rating
Met
Findings
-

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
Evidence Reviewed
The health service organisation provides feedback to the workforce at regular intervals. Currently appraisals are completed annually. Staff describe the process for them to identify any additional learning needs. The NUM is responsible for the performance review of their staff. Reporting of compliance is monitored and reported to management as a KPI for the managers. Staff files reviewed demonstrated compliance with annual appraisals. In Maternity, the NUM described delegating the responsibility for appraisals to the six level 2 clinical nurses. GA completed 23/1/23, SM 21/1/23 and JA 22/10/22.
Rating
Met
Findings
-

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
Evidence Reviewed
Healthscope Corporate Accredited Health Practitioners Credentials policy 1.20 06/22. Scope of practice is defined as a component of credentialling. The facility is required to document what qualifications are required for each role. Midwives are recruited for maternity services, for example. If the incumbent does not have all requirements, the individual is required to undertake a training program. Any staff training is monitored and the employee is mentored. VMO are assigned scope of practice based on their college training and admitting rights to ensure their scope is clearly defined prior to service precision. Interim rights may be granted depending of scope of proactive and risk. All applications are initially for one year, then a further 5 years is granted. The adoption of new technologies is described in the Bylaws/Facility Rules. GCOV is used by Healthscope for credentialling. A review was undertaken and cross referenced against the most recent MAC minutes from
Rating
Met
Findings
-

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
Evidence Reviewed
There is a formal credentialling process for clinicians designed to reflect their scope of practice. AHPRA registration is monitored annually for nursing and allied health staff.

Credentialling of medical officers is described in the Bylaws/Facility Rules.

The Medical Advisory Committee (MAC) review and approve all new visiting medical officers. Scope of practice is defined in the approval letters sent following MAC approval.

Credentialling is completed every 5 years following an initial period of 12 months.

Mandatory education, college clinical education, immunisation, and insurance is monitored.

A review of VMO files was undertaken during the assessment

Compliance to stated requirements was confirmed.

The effectiveness of the credentialling process is monitored via the MAC. The last meetings was the 28/8/23. A selection of VMO who were credentialled at this meetings and their files were sampled. An O&G, Haematologist, Haematology Registrar and anaesthetics were sampled. Processes were consistent with a clear scope of practice defined in the approval letters written by the CEO.

CCRTGE certification was sighted for Dr GW 3/5/10 and NI 1/5/14. both were credentialled for adult colonoscopy which was cross referenced in the files of two patients who underwent colonoscopy

Rating

Met

Findings

-

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

Evidence Reviewed

Job descriptions contain statements about requirements for incorporating safety and quality principles for staff when fulfilling their role. The facility uses agency nursing staff to ensure appropriate staffing numbers consistent with clinical activity. Agency staff receive an orientation from a staff member.

Agency staff are orientated to the hospital Records sighted of the log sheet to verify compliance. On the 4/9/23 PS, JL and RS were signed off. On 29/8/23 JM attended.

Examples of position descriptions included statements that the Enrolled nurse will work under the supervision of the Registered Nurses.

Upon review of staff files, #3086749, #3059214 and #3069010 were provided with position descriptions documented for the appropriate role.

Rating

Met

Findings
-

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
Evidence Reviewed
There is an intensivist present in ICSU 24 hours per day, in addition there is an emergency department staffed 24 hours. A House office is present between 930hours and 22 daily. Each ward has a NUM and clinical nurses. After hours, Nursing Supervisors are present in the hospital. The MAC chair is available to staff at any time, as is the director of nursing. The MAC Chair and Director of Nursing are available to the staff.
Rating
Met
Findings
-

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
Evidence Reviewed
Sufficient tools and information is available to clinicians at the point of care. Tools include but are not limited to Clinical Care Standards Injectable Handbooks AMS prescribing guidance Therapeutic Guidelines

eMIMS are available on all computer desktops

There are clinical pathways linked to the care needs identified in the comprehensive assessment process at pre-admission or admission.

Rating

Met

Findings

-

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

Evidence Reviewed

Variation in practice is monitored through the organisation submitting their outcomes to clinical indicator data sets. Data from these bodies enables feedback to clinicians and drive benchmarking activities. Data is reconciled with the incident and complaint management systems to ensure any individual variation is identified and discussed at MAC and the Quality and Safety Committee.

Discussion with the CEO and DON demonstrated a sound knowledge of this process. The ability of the hospital identify any unwarranted clinical variation was discussed with the MAC Chair. He described multiple inputs into recognising deviation from expected process. The incident management system, RiskMan would highlight clusters, craft groups tend to be vocal regarding the performance of their specialty.

Minutes of the MAC/Safety and Quality meeting were sighted. Individual Mortality and Morbidity Meetings for each of the 19 specialties are held quarterly, minutes demonstrated discussion of adverse events and feedback. A Clinical Review Committee is convened quarterly and chaired by MAC Co-Chair (Infectious Disease Specialist)

Rating

Met

Findings
-

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
Evidence Reviewed
The facility has a preventive maintenance program. All biomedical equipment and Body protection areas contained compliance plates sighted during the assessment were noted to be in date. Sampling of records include TMV, monthly temperature testing , legionella testing, Theatre air conditioning)(HEPA and air changes) and backflow reports were sampled. Processes are in place to ensure that infrastructure is fit for purpose. There is also a reactive maintenance process for staff to quickly respond to breakages in order to minimise patient risk.
Rating
Met
Findings
-

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
Evidence Reviewed
There are documented policies for aggression management. Emergency Plans and internal phone directories are available for staff. Emergency flip charts where sighted in appropriate locations with staff confirming when they would be used. Emergency and Safety Procedures which informs patients about taking direction from staff in the event of a fire or smoke alarm activation are included in the Business Continuity Plan.

Duress alarms are available in all areas.

Nurse call pendants are also available in all areas.

There is restricted entry into the hospital after hours. Maternity is a locked ward

The patient accommodation, with predominately single rooms creates good opportunities to provide safer places to provide a calm and quieter environment when clinically required. Instances of unpredictable behaviour are reportedly rare.

Common rooms are available for patients in areas of potential risk. These include, reception, accident and emergency, recovery and mental health ward areas. Each have access to quiet spaces.

Rating

Met

Findings

-

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

Evidence Reviewed

Signage is clear and sensible.

Braille is included in the elevators, there is a patient and visitor directory

The hospital has a front desk and volunteers act as a concierge during the day. The hospital

Rating

Met

Findings

-

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

Evidence Reviewed
Discussions with management and staff confirmed that the HSO has flexible visiting arrangements to meet patients needs with overnight stays permitted if clinically indicated. Examples provided include social support, if the patient is a minor, during end of life care or for parents of newborns. The Patient Information Guide has information about visiting arrangements.
Rating
Met
Findings
-

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
Evidence Reviewed
The Governing Body has approved the strategic plan for ATSI clients. Acknowledgment of Country is conducted before meetings. Cultural Diversity, Sensitivity and Responsiveness Policy informs staff how to deal with the needs of Aboriginal and Torres Strait Islander (ATSI) patients and their carers and families, in addition to the evidence provided demonstrated local community input about the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. The environment has been adjusted to welcome ASTI people with the use of artwork and signage. When an ATSI client is identified, the Liaison staff from the co-located Gold Coast University Hospital will come and ensure appointment support is provided and transport is facilitated.
Rating
Met
Findings
-

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

Evidence Reviewed

Corporate policies describing the process of Partnering with Consumers include:
Policy 1.05 Partnering with Consumers
Policy 2.06 Consumer Approved Publications
Policy 1.08 Complaints Management
Consumer representatives undergo Orientation and Training for the role.
Confidentiality agreements are signed, this was sighted for LM on 30/10/2018
Consumer engagement is referenced in the organisation Risk Register when discussing customer satisfaction.

Rating

Met

Findings

-

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

Evidence Reviewed

The Clinical Governance Framework outlines the organisation's processes for monitoring partnering with consumers. This mandates the consumer engagement processes for the hospital and how the outputs are reported to the highest level of governance and how improvement strategies are identified and implemented.

The Consumer Representatives confirmed her input into the hospital via multiple means. Through visiting patients weekly and seeing between 5 and 10 per day. Conversations are journalled. Feedback is provided to the clinical management team.

Rating

Met

Findings
-

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
Evidence Reviewed
Australian Charter of Healthcare Rights (ACHCR) is in use and on display throughout the facility. The facility ensures patients read and understand the Australian Charter of Healthcare Rights and Privacy Policy at pre-admission/admission or on arrival.
Rating
Met
Findings
-

Action 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Evidence Reviewed
There is a documented policy which addresses informed consent, 2.17. All Medical records sighted during the review contained a signed consent. Monitoring of informed consent is via the internal audit program. Approximately 20 medical records were reviewed with appropriate consents included. Informed Financial is sought and meets the requirements of the Advisory AS 18/10.
Rating
Met
Findings
-

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
Evidence Reviewed
There is a documented policy which addresses the capacity of patients to consent to treatment and to involve a substitute decision maker. There is a process in place for checking for Enduring Power of Attorney and Advance Health Care Directives. This was verified in the medical records reviewed in accordance with Policy 2.56 Advance Care Directives. Staff have access to TIS interpreter services in accordance with the associated Interpreter Services policy 2.26.
Rating
Met
Findings
-

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
Evidence Reviewed
Staff are supplied with information and Inservice training on how to identify Goals of Care for patients. There is a procedure included in the Comprehensive Care policy for identifying goals of care . White Boards are available in the patient rooms and have recently been upgraded in response to staff and client feedback. Goals of care are very individual to the clinical service provision of each ward. Clinical Handover was witnessed in several clinical areas to confirm that clinicians partner with their patients to plan, communicate and make decisions about care.
Rating
Met
Findings
-

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
Evidence Reviewed
Patient centred care is described in the Comprehensive Care Policy 2.69. Staff describe and were witnessed using a structured handover tool, ISBAR. Patients interviewed during the assessment confirmed the clinical handover policies includes the patient and their family. Goals of care or 'What matters to me today" are identified and communicated. Assessors observed full engagement of patients and family (where present) with appropriate information being disseminated to patients during the bedside handover. This shared decision making for ongoing care is documented in the comprehensive care plan.
Rating
Met
Findings
-

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
Evidence Reviewed
The diversity of the population is mainly English speaking and relatively homogenous. The Australian Charter of Healthcare rights (ACHCR) is available in a number of different languages to patients and is monitored through the various bedside audits completed at departmental levels. The ACHCR is displayed in patient waiting areas. Other than English, the two most common languages as Finnish and Cantonese.
Rating
Met
Findings
-

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
Evidence Reviewed
Corporate policies on consumer participation include how information is reviewed by consumers, families and their carers. The Local consumer Representative is very engaged in the review of patient information and data provided by the facility. Healthscope have a Consumer Endorsed program for the review of patient facing information. This program is administered by the Quality and Safety Committee. The Hospital compendium is available via a QR Code.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinical areas were accessed by the assessment team to ensure the organisation supports their staff to communicate with consumers regarding their health care. If necessary, staff will arrange for an interpreter to ensure that communication with a patient is meaningful. The patient information booklet has been prepared to provide patients with information about the hospital's services with the booklet prepared with consumer input. The patient information available on the web site includes Preadmission care centre, Day surgery, Discharge, Overnight stay, Nearby accommodation, Maps, Payment information, What to bring, Smoke free campus There is a patient Compendium (general) and one for Maternity. Information on Cognitive impairment and falls is also provided both on the website and in hard copy if requested

Staff describe the following policies and processes.
Communicating for safety
Handover
Communication Boards
Diversity of consumers
Discharge advice (including My Health Record integration)
Clinical handover using ISBAR was witnessed during transitions of care which adhered to the stated policies.
The discharge of patients is included in the WebPAS system and is a component of the integration of My Health Record at Gold Coast Private.

Rating

Met

Findings

-

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

Evidence Reviewed

Consumer engagement occurs in two ways. Firstly, via patient centred care at the clinical interface.

The second means is via a consumer representative. Their role is to review the safety and quality data for the facility and provide feedback to the governing body.

Information on safety and quality data is fed back to the patients via quality boards in the clinical areas.

The diversity of consumers is assessment regularly by the Quality Team with a report provided. The local Aboriginal Support Service is accessible to the Hospital as required.

Rating

Met

Findings
-

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
Evidence Reviewed
There is a Consumer engagement policy in place which includes a structured orientation for Consumers Representatives. An orientation to the hospital, and information on the NSQHSS is included. During the assessment the Assessor has an opportunity to meet with the Consumer Representatives who confirmed her orientation to the role. Records confirm this occurred on the 30/10/2018
Rating
Met
Findings
-

Action 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Evidence Reviewed
Healthscope has approved the strategic plan for ATSI clients. Acknowledgment of Country occurs as required. Cultural Diversity, Sensitivity and Responsiveness Policy informs staff how to deal with the needs of Aboriginal and Torres Strait Islander (ATSI) patients and their carers and families, in addition to the evidence provided demonstrated local community input about the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.
Rating
Met

Findings
-

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
Evidence Reviewed
Quality Improvements resulting from patients feedback are incorporated into staff training via the interactions with the consumer representative. During the assessment the Assessment had the opportunity to meet with several consumers and to read the feedback provided to the consumer representative. The Consumers Representative confirmed her orientation and confidentiality requirements. Quality Boards have been installed in each department to display feedback and performance data to both patients and staff.
Rating
Met
Findings
-

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
Evidence Reviewed
Assessors reviewed infection control procedures and processes 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. Infection Prevention and Control - HICMR Policies and Services - 15.04.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH reports any infection prevention and control associated risks through the regular committee structure (See action 1.01). GCPH has specific responsibilities for improving infection prevention surveillance and workforce training which was evidenced to the assessors.
Rating
Met
Findings
-

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

Evidence Reviewed

GCPH has a comprehensive audit schedule for infection prevention and control systems and audit results are provided to staff and data is provided through the committee structure. Infection control and prevention and antimicrobial stewardship are discussed at staff and consumer focus meetings and strategies are documented to improve performance where gaps are identified. Staff are informed via meetings and on noticeboards of all infection control audit results and any actions required.

Rating

Met

Findings

-

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

Evidence Reviewed

Patients and staff interviewed by assessors were able to describe the actions taken to involve and inform them about infection prevention and control and AMS measures. At GCPH information is available to patients, carers and families in a format that is easily understood.

Rating

Met

Findings
-

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
Evidence Reviewed
GCPH 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 through the committee structure. The organisation is compliant with Advisory AS20/02.
Rating
Met
Findings
-

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

Evidence Reviewed
The review of infection control documents at GCPH specifically transmission based precautions indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare standard. Healthscope Standard and Transmission-Based Precautions - 15.03.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has policies and processes for the management of organisms-specific risks, including prevalence in the community is in place that are consistent with jurisdictional and Public Health advice (COVID). Fit testing/checking training is undertaken, with adequate PPE available for all staff. Documentation and communication of infectious status is included with all pre-op documentation and communication is included in transfer of care and discharge processes. GCPH staff undertake mandatory training for the appropriate use of standard and transmission-based precautions.
Rating
Met

Findings
-

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
Evidence Reviewed
Procedures are available for implementing standard and transmission-based precautions and all staff. Staff were able to confirm their use and understanding of these measures and risk screening procedures. GCPH is designed to effectively manage infection risks. Environmental management and cleaning practices are consistent with policy.
Rating
Met
Findings
-

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
Evidence Reviewed
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 with posters describing the required precautions at the entry points of clinical areas.
Rating
Met
Findings
-

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
Evidence Reviewed
The Hand Hygiene program is consistent with the current National Hand Hygiene Initiative (NHHI) and jurisdictional requirements. The organisation has access to Hand Hygiene auditors that have undertaken the NHHI training. Regular compliance and observational audits are undertaken and provided to staff and through the committee structure and displayed on staff boards. Current compliance rates are 100%. The organisation is compliant with the requirements of Advisory AS20/01.
Rating
Met
Findings
-

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
Evidence Reviewed
Processes for aseptic technique are in place. Staff are appropriately trained, and competency / compliance is monitored. Assessor was able to review audit results and identified training compliance of 98%.
Rating
Met
Findings
-

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 Healthcare17
Evidence Reviewed
Training and assessment for the management of invasive devices are available to staff and align with the current best practice.
Rating
Met
Findings
-

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 Healthcare17 and jurisdictional requirements – to:

a. Respond to environmental risks, including novel infections

b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies

c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections

d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy

e. Use the results of audits to improve environmental cleaning processes and compliance with policy

Evidence Reviewed

Cleaning procedures and schedules are in place with regular auditing and reports made available through the committee structure. A sample of cleaning schedules for GCPH were visualised by the assessors and staff interviewed regarding cleaning processes had a good knowledge and understanding of the cleaning requirements.

Rating

Met

Findings

-

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

Evidence Reviewed

GCPH has infection control processes, policies and procedures to respond to infection risks for equipment, devices, products, buildings and linen that is responsive to novel infections risks and pandemic planning. All new products are reviewed and assessed for infection related risk. Maintenance is both scheduled and responsive to failure.

Rating
Met
Findings
-

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
GCPH has comprehensive workforce immunisation program in place that complies with the jurisdictional policy and national guidelines. Immunisation status is captured during the recruitment process. There is an annual influenza vaccination program and a COVID-19 vaccination program is in place.
Rating
Met
Findings
-

Action 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection

g. Provide for outbreak monitoring, investigation and management

h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection

Evidence Reviewed

GCPH has an annual influenza vaccination program and 100% of the workforce are fully vaccinated for COVID-19.

There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. The program for workforce screening and workplace exclusion is aligned with (State) Health directions.

A tiered approach to outbreak and pandemic planning and management is in place.

Rating

Met

Findings

-

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

Evidence Reviewed

Available infection control documents indicate that processes are in place for quality management of reprocessing reusable equipment, instruments and devices including: Infection Prevention and Control - HICMR Policies and Services -15.04 and Cannulated Instruments - Cleaning of - 12.06.
A progress plan is in place to address the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory AS18/07 regarding compliance to AS4187. The assessors observed processes and flows that have been implemented ensured an efficient process with all RMD's meeting AS4187 standard and ACSQHC Advisory AS18/07. Interviews with management and staff involved in reprocessing RMDs confirmed that relevant national standards are followed.

A traceability process is in place that facilitates routine monitoring and recall when required.

Assessors additionally reviewed water quality documents.

Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has established an antimicrobial stewardship program that is guided by evidenced based policy. The AMS Program is implemented by the AMS committee, with local formulary approval, education, monitoring and corrective action as required. 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). Antimicrobial Stewardship in GCPH and TDS - 13-035.
Rating
Met
Findings
-

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

Evidence Reviewed

GCPH documentation showed that the antimicrobial stewardship program is audited to review the antimicrobial prescribing and use, including surveillance data on antimicrobial resistance. The program is evaluated and performance is monitored with reports provided to clinicians via the AMS committee. 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

Met

Findings

-

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

Evidence Reviewed

The HSO has in place systems for safety in the supply, storing, prescribing and administration of medication which is outlined in Medication Safety Governance Policy. Medication Governance processes include a suite of policies and procedures related to medication management and safety, the inclusion of medication risks and their controls within the HSO Risk Register, and learning platforms for training which include medication related modules for the workforce and related medication, educational in-services, and committee frameworks to review medication related quality and safety data

Rating
Met
Findings
-

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
Evidence Reviewed
The HSO has established the Standard 4 Committee and the Pharmacy Committee for reviews on performance and effectiveness of the governance processes. These include review of quality improvement activities, review of medication related policies and procedures, review and management of medication related risks included in the HSO Risk Register, medication authorities and safety processes, audits schedules and their results, and training/competencies requirements of the workforce. Outcomes from these Committees are inputs within the HSO Committee Frameworks, including tabling at the GB committee for review and management.
Rating
Met
Findings
-

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

Evidence Reviewed
The HSO was observed to conduct a collaborative engagement with its patients and carers in medication management. Information was provided on consistent basis throughout the patient journey where medication administration was to be conducted and consent processes being in place. Processes for education on discharge medication are provided to the patient and carer in a clear and easily understood manner. Patients and/or carers are encouraged to ask questions and importantly report any side effects or other reactions they may be experiencing. Interviews with the consumer representative verified these processes and their inclusion to the Standard 4 and Pharmacy Committees for the provision of review of safety and quality data and consumer input to the design of processes related to medication management.
Rating
Met
Findings
-

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
Evidence Reviewed
Processes are in place for ensuring that all relevant clinicians operate within their medication scope of clinical practice. Any non-conformances are managed through the Incident management system and reported for executive review and control through the committee frameworks. Processes were verified through the review of incidents within RiskMan and review of committee meeting minutes
Rating
Met
Findings
-

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

Evidence Reviewed
Clinicians take a best possible medication history on admission utilising pre-admission information provided by the patient, family members and or referring medical practitioner. Important information is related to allergies or any adverse drug reactions are recorded as alerts within the healthcare record and is communicated to the team during handover processes
Rating
Met
Findings
-

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
Evidence Reviewed
The review of prescribed medications against a patient's initial best possible medication history is ongoing and forms part of the treatment plan for all patients. Communication of medication related information forms part of a structured handover processes during transitions of care
Rating
Met
Findings
-

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
Evidence Reviewed
The process for identifying and documenting medication allergies and adverse drug reactions is defined and monitored. Sampling of patient records verified these processes and was observed during episodes of patient care

Rating
Met
Findings
-

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
Evidence Reviewed
The HSO has an incident management system (RiskMan) where all medication related incidents, including adverse drug reactions are recorded. Documentation within the patient healthcare record of any medication related allergies or adverse drug reactions was verified with medical record sampling and interviews with staff
Rating
Met
Findings
-

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
Evidence Reviewed
Policies and guidelines are in place to report adverse drug reactions experienced by patients in their care journey to the Therapeutic Goods Administration
Rating
Met
Findings
-

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
Evidence Reviewed
Medication reviews are practised in line with best practice guidelines. Medication reviews may be based on a patient's clinical presentation, pre-admission medication prescriptions or due to a change in medication treatment.
Rating
Met
Findings
-

Action 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Evidence Reviewed
Information for patients on specific medications are available to clinicians and are appropriate to the patient cohort
Rating
Met
Findings
-

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

Evidence Reviewed

The HSO has on site pharmacy services that assist with oversight and management of medication lists for patients at certain touch points during the patient journey. A component of this is medication reconciliation and discharge documentation. This includes a current medication list with information related to their discharge medication regime and is provided and explained to the patient and or carers.

Rating

Met

Findings

-

Action 4.13

The health service organisation ensures that information and decision support tools for medicines are available to clinicians

Evidence Reviewed

Medication prescribing decision support tools are readily available for clinicians including Therapeutic Guidelines and are available and accessible to clinical staff.

Rating

Met

Findings

-

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

Evidence Reviewed
The HSO adheres to the jurisdictional requirements for the safe and secure storage, recording and administration of medication as evidenced by assessors. The storage of temperature sensitive medicines, storage, disposal was all evidenced with records maintained.
Rating
Met
Findings
-

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
Evidence Reviewed
Interviews with staff and review of supporting documents and assessor observations 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. Scheduled drugs are recorded in appropriate registers and are part of the audit framework
Rating
Met
Findings
-

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

Evidence Reviewed
The requirements of this action are well supported by the management of GCPH through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards, support clinicians to deliver comprehensive care. Assessors reviewed the following documentation: Comprehensive Care Plan 2.69 Sept 2019 Comprehensive Care Plan - Daily HMR 6.13F or 6.13H Comprehensive Risk Screening Tool 2.70 Sept 2019 Wound Care Assessment & Plan HMR 7.12 Falls Prevention and Management - Patient 8.04 Policy Pressure Injury - Prevention, Identification and Management of 8.05 May 2021 Comprehensive Skin Assessment HMR 6.13G (or HMR 6.13J Braden Scale, or HMR 6.131 MH) Management of Skin Integrity in CP - Admission & D/C Alert Form Delirium and Cognitive Impairment Prevention and Management Policy 8.94 July 2022 Comprehensive Risk Screening Tool HMR6.13G & 4AT HMR6.27 Self-Harm and Suicide (Threatened, Attempted and Completed) in a Non-Mental Health Facility 2.54 Nov 2019 Restrictive Practices - Patient Restraint (Non- Mental Health Facilities) 8.95 October 2019
Rating
Met
Findings
-

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
Evidence Reviewed
Comprehensive care is defined and monitored with outcomes and audits reviewed at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. GCPH uses feedback, data and outcomes together with evidenced based practice to support improvements in care. Assessors reviewed EQuAMS #6263 Comprehensive Care 31/08/23.

Rating
Met
Findings
-

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
Evidence Reviewed
Processes are in place to partner with patients in their care and associated decision-making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. Assessors observed staff and clinician interviews with patients throughout the entire patient journey, that were patient centred and involved shared decision-making.
Rating
Met
Findings
-

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

Evidence Reviewed
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. GCPH operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processed for referral where needed. The clinician with overall accountability for a patient's care is defined as admitting VMO at GCPH. Documentation as per 5.01.
Rating
Met
Findings
-

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
Evidence Reviewed
Roles and responsibilities are clearly defined through contracts and position descriptions. A system is in place for orientation, performance review and ongoing education.
Rating
Met
Findings
-

Action 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Evidence Reviewed
The assessors witnessed collaborative engagement with patients receiving care and with family and carers, where required, to screen for risk. A range of policies and procedures are in place to support the clinical team to deliver comprehensive care. Documentation as per 5.01.

Rating
Met
Findings
-

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
Evidence Reviewed
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Staff 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. Documentation as per 5.01.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has processes in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. The intent of AS 18/04 is met.
Rating
Met

Findings
-

Action 5.09
Patients are supported to document clear advance care plans
Evidence Reviewed
There is a process for receiving and documenting advance care plans if required, as per Advanced Care Directives 2.56 July 2022.
Rating
Met
Findings
-

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
Evidence Reviewed
A comprehensive assessment is conducted on admission. Risk screening processes are subject to audits and reports are reviewed at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. A limited review of clinical documentation by the assessors verified this. Documentation as per 5.01.
Rating
Met
Findings
-

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Evidence Reviewed
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Documentation as per 5.01.
Rating
Met
Findings
-

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Documentation reviewed by the assessors demonstrated that processes are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. Staff interviews and assessor observation of patient admission confirmed robust documentation. Variances are collated through RiskMan and reported at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. Documentation as per 5.01.
Rating
Met
Findings
-

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

Evidence Reviewed

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 discharge planning is initiated as early as possible in the patient's journey. The assessors witnessed interactions between staff, patients, their carers and families that demonstrated this partnership in

care and decision making. The requirements of Advisory AS18/15 have been met.

Rating

Met

Findings

-

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

Evidence Reviewed

Consumers have an opportunity to be involved with the clinical care and decision-making through pre-admission, admission and discharge procedures and consumer feedback mechanisms - RiskMan. Evidence provided supported that the care planning process is patient centred and well documented.

Rating

Met

Findings

-

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
Evidence Reviewed
GCPH 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. Assessors reviewed: Policy Death of a patient 01/005 November 2022; Policy Deaths, In Hospital - Reviews of 2.48 August 2022; Comfort Observation and Symptom Assessment Chart - Adult; Medical Orders for Life-Sustaining Treatment MOLST HMR 1.1; Palliative Care Subcutaneous Infusion MR 10.12; Advanced Care Directives 2.56 July 2022.
Rating
Met
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
GCPH provide clinicians with access to specialist palliative care advice including a Palliative Care Physician, Oncologists, Haematologists and a team of oncology nurses, pastoral carers and the allied health team.
Rating
Met
Findings
-

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

Evidence Reviewed
Advanced Care Plans received from patients are documented on the patient's health record as per Advanced Care Directives 2.56 July 2022.
Rating
Met
Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Evidence Reviewed
GCPH provides supervision and support for the workforce providing end-of-life care. Assessors verified this through: In-Service Attendance Record Ward 3 Voluntary Assisted Dying; Converge International – Let's Chat phone numbers and appointments for all staff; Ward Call Request/Referral Form MR 495R.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH routinely reviews the safety and quality of end-of-life care that is provided against the planned goals of care using RiskMan, Mortality/Morbidity Register and the Mortality Spreadsheet 2023.
Rating
Met

Findings
-

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
Evidence Reviewed
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, as per Comprehensive Care Plan 2.69 Sept 2019, Policy Death of a patient 01/005 November 2022; Policy Deaths, In Hospital - Reviews of 2.48 August 2022. The assessors reviewed Patient Brochures/Information including: Preparing for End of Life B-21 V4 June 2018 and Understanding Your Grief - Some suggestions that may help.
Rating
Met
Findings
-

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
Evidence Reviewed
There is provision for a skin assessment to be performed on admission and reviewed on discharge. Pressure injury incidents are reported in RiskMan and reviewed and monitored at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. Assessors reviewed Pressure Injury, Prevention and Management of 8.05 May 2021.
Rating
Met
Findings
-

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
Evidence Reviewed
Appropriate care and advice is given, with staff ensuring that the primary teams are aware of any compromise to skin integrity. Any pressure injuries are recorded in the RiskMan. Regular audits are built into the annual audit schedule.
Rating
Met
Findings
-

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
Evidence Reviewed
Staff have appropriate equipment available to them to aid in managing risks to skin integrity. Equipment, products and devices, including positioning gel pads and other positioning accessories, are available to prevent and manage pressure injuries, the assessor witness these products in use.
Rating
Met
Findings
-

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

Evidence Reviewed

All patients are assessed on admission against a standardised screening tool. Incidents are reported into RiskMan and data related to falls is analysed and reported through the Quality, Clinical Review, Medical Advisory and Executive Committee meetings.

Rating

Met

Findings

-

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

Evidence Reviewed

All patients are assessed on admission against a standardised screening tool. Those patients that are identified as a falls risk are managed as per Falls Prevention and Management - Patient 8.04 Policy. All falls are reported into RiskMan and data related to falls is analysed and reported through the Quality, Clinical Review, Medical Advisory and Executive Committee meetings.

Rating

Met

Findings

-

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

Evidence Reviewed
Information is available to patients, their carers / families about falls prevention and risk management strategies.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice, as per Diet and Nutrition - Adult Inpatients 8.27 July 2022.
Rating
Met
Findings
-

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
Evidence Reviewed
Patients’ nutritional and hydration requirements, preferences, allergies and special dietary needs are identified and assessed on admission.

Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has systems in place to care for patients who have cognitive impairment or are at risk of developing delirium as per Delirium and Cognitive Impairment Prevention and Management Policy 8.94 July 2022. Early recognition, prevention, treatment and management are identified using the Comprehensive Risk Screening Tool Policy 2.70 Sept 2019 and the Comprehensive Risk Screening Tool HMR6.13G & 4AT HMR6.27 Forms.
Rating
Met
Findings
-

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

Evidence Reviewed
GCPH has implemented processes for recognising, and managing patients with cognitive impairment, with instructions to prompt nursing staff when to seek further medical assessment incorporated into the pre-admission and patient registration form. Documentation as per 5.29.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has systems in place to support collaboration with patients, carers and families to identify when a patient is at risk of self-harm or suicide, as per Self-Harm and Suicide (Threatened, Attempted and Completed) in a Non-Mental Health Facility 2.54 Nov 2019. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts, as per Self-Harm and Suicide (Threatened, Attempted and Completed) in a Non-Mental Health Facility 2.54 Nov 2019.
Rating
Met
Findings
-

Action 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Evidence Reviewed
GCPH has procedures in place to take action on behalf of a patient/other who is presenting as aggressive or at risk of harm to themselves or others, as per Occupational Violence and Aggression Management - Principles and Prevention 6.15 April 2020 and Removal or Exclusion of Persons from Premises 1.11 July 2022. Any incident involving aggressive or violent patients are reported on RiskMan and reviewed and monitored at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. Assessor reviewed Diversional Box Project eQuAMS # 5540 and observed box on the ward.
Rating
Met
Findings
-

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

Evidence Reviewed

Processes are in place to guide and support staff in the identification of situations that may result in aggressive behaviour, and how to manage them. Staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression are reported in the RiskMan. Assessors observed Emergency Procedures Flip Charts available with phones and throughout the facility. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation. Staff undertake Healthscope - WAVE 1 - Managing

Conflict & Challenging Behaviour training and education.

Rating

Met

Findings

-

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

Evidence Reviewed

Assessors reviewed Restrictive Practices - Patient Restraint (Non- Mental Health Facilities) 8.95 October 2019.

Rating

Met

Findings

-

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
Evidence Reviewed
As per Advisory 18/01
Rating
Not Applicable
Findings
-

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
Evidence Reviewed
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. Assessors viewed supporting documentation and witnessed various processes related to clinical communication. Patient Rounding 2.63 Aug 2022 Admission of Patient - Acute Medical/Surgical Hospital 2.65 Oct 2020 Discharge of a Patient 2.50 July 2022 Clinical Handover - Departmental and Intra Unit 8.08 October 2020 Patient Identification Bands 2.08 Nov 2021 Correct Patient, Correct Procedure, Correct Site 2.15 July 2022 Discharge of a Patient - Against Medical Advice 2.51 Aug 2020
Rating
Met

Findings
-

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
Evidence Reviewed
Incidents relating to failure in clinical communication are reported through RiskMan and identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover is monitored through feedback and audit.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has procedures and policy that support the engagement of patients, their carers and families in their own care and shared decision making process. Patients are involved in clinical handover and verification of this was witnessed by the assessors. Patients who were interviewed (MRN #175774, #377223 and #810989) reported being engaged in their care and that they had adequate information available to them to make informed decisions about their care.

Rating
Met
Findings
-

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
Evidence Reviewed
Policies and processes are in place to support appropriate identifiers are used in procedure matching, transfer of care, handover, discharge and where changes in clinical care/patient risk profile are identified. Documentation viewed by the assessors supports the use of specified identifiers in these situations. Documentation as per 6.01.
Rating
Met
Findings
-

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

Evidence Reviewed
GCPH 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 verified this when observing clinical handover - MRN 811377, 707444, 521010, 168363, 377223, 810989 and 166920.
Rating
Met
Findings
-

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
Evidence Reviewed
The assessors noted the use of approved patient identifiers throughout the facility during the assessment. Additionally, processes are in place for surgical/procedural time-out, this is documented and audited. In the maternity ward, two arm bands are applied to babies prior to leaving the delivery room (theatre or labour ward) During the assessment it was verified that these bands are reconciled with the mother at the time of clinical handover.
Rating
Met
Findings
-

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

Evidence Reviewed

Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient as well as the clinicians involved in the handover. Compliance with these requirements is audited and reported to the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. Staff interviewed could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover. The assessors observed clinical handovers throughout the facility and these confirmed the documented processes.

Rating

Met

Findings

-

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

Evidence Reviewed

The assessors witnessed clinical handover that was structured and effectively engaged with patients, their carers and families in defining goals of care and decision making during the pre-admission and discharge processes. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. Both patients and staff were able to articulate the process of handover and

provide confirmation of patients, care and family in decision making. Documentation as per 6.01.

Rating

Met

Findings

-

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
Evidence Reviewed
GCPH has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Clinical handover involves patients, their carers and families as required. Clinical handover is audited, and incidents/feedback related to communication issues are addressed appropriately. Documentation as per 6.01.
Rating
Met
Findings
-

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
Evidence Reviewed
Documentation reviewed verified that there are communication processes in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients/carers interviewed confirmed this process and the assessors observed information available to support and facilitate this process, including "Communicating with your Healthcare Team - Patient, Family and Carer Escalation" posters observed in all patient rooms and throughout the hospital.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinical documentation reviewed by the assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information and the recording of this in the patient healthcare record.
Rating
Met
Findings
-

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
Evidence Reviewed
The requirements of this action are well supported by the management at GCPH through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards support clinicians to deliver blood management.
Rating
Met
Findings
-

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
Evidence Reviewed
Blood management is defined and monitored with a wide range of quality improvement strategies in place. Regular reporting occurs through the committee structure with escalation to the highest governance as required. The organisation uses feedback, data and outcomes together with evidence based practice to support improvements in blood management.
Rating
Met
Findings
-

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
Evidence Reviewed
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this and patients reported that they felt actively involved and informed about their care.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinicians are supported by policies and procedures to establish safe and effective blood management practices. Blood Fridge Management and Unused Blood Products - 8.64a, Blood Transfusion (Emergency) of Unmatched Red Cells - 8.63, Blood Transfusion - Management of Patient, Blood and Blood Products - 8.64, Blood Transfusion - Massive - 8.62, Patient Blood Management (PBM) - 8.61, Jehovah's Witnesses and Blood Transfusions - 8.87.
Rating
Met
Findings
-

Action 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Evidence Reviewed
Documentation reviewed by the assessors demonstrated that processes are in place to obtain and record blood transfusion history and details in the patients medical record.
Rating
Met
Findings
-

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

Evidence Reviewed
GCPH has processes and procedures in place to support clinicians in the safe and appropriate practice of prescribing and administering blood and blood products.
Rating
Met
Findings
-

Action 7.07
The health service organisation uses processes for reporting transfusion- related adverse events, in accordance with national guidelines and criteria
Evidence Reviewed
GCPH has processes in place for reporting of transfusion-related adverse events which are consistent with national guidelines and criteria.
Rating
Met
Findings
-

Action 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Evidence Reviewed
Hemovigilance activities are conducted through the Blood Transfusion Committee and the Standard 7 Working Group and are consistent with the national framework.
Rating
Met

Findings
-

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
Evidence Reviewed
GCPH has processes in place to comply with manufacturers directions and be able to trace blood and blood products from entry into the organisation including blood fridge temperature records and a blood register.
Rating
Met
Findings
-

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
Evidence Reviewed
GCPH has process in the place to manage the availability, eliminate waste and respond in times of shortage through QML pathology onsite.
Rating
Met

Findings
-

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
Evidence Reviewed
GCPH has policies and procedures in place to recognise and respond to acute deterioration and staff were able to describe their role on such events. Documentation reviewed by assessors includes: Clinical Deterioration, Recognising and Responding to 8.45 October 2022; Delirium and Cognitive Impairment Prevention and Management 8.94 July 2022; Anaphylaxis, Management of 8.88 July 2023 July 2023; Advanced Life Support (ALS) - Adult 8.13 July 2022; Cardiac Surgical Advanced Life Support (CALS) 8.60 October 2022. Risks and training needs are identified, and training records were made available to the assessors.
Rating
Met
Findings
-

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
Evidence Reviewed
Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute

physiological deterioration, the National Consensus Statement: Essential elements for safe and high-quality end-of-life care, the National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state, and the Delirium Clinical Care Standard.

Rating

Met

Findings

-

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

Evidence Reviewed

GCPH has documents that were reviewed to show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. GCPH consent to treatment process includes involving patients, meeting their information needs and shared decision making. The assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients. Assessors observed "Communicating with your Healthcare Team - Patient, Family and Carer Escalation" posters in patient rooms and on walls around the facility.

Rating

Met

Findings

-

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

Evidence Reviewed
Vital signs are monitored graphically and in accordance with GCPH policy using GCPH observation charts. 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 / intervention as per Clinical Deterioration, Recognising and Responding to 8.45 October 2022.
Rating
Met
Findings
-

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
Evidence Reviewed
Policies and procedures support staff in identifying acute deterioration in mental state including the risk or delirium - Clinical Deterioration, Recognising and Responding to 8.45 October 2022 and Delirium and Cognitive Impairment Prevention and Management 8.94 July 2022. GCPH clinical pathways documentation reviewed by assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration and/or delirium. Clinical documentation is audited regularly for compliance with documentation of any acute deterioration. 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
Met

Findings
-

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
Evidence Reviewed
GCPH 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, RiskMan incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to the assessors, 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 (8.6 b,c,d,e)
Rating
Met
Findings
-

Action 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Evidence Reviewed
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Assessors observed "Communicating with your Healthcare Team - Patient, Family and Carer Escalation" posters in patient rooms and on walls around the facility.

Rating
Met
Findings
-

Action 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Evidence Reviewed
GCPH 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 assessors were provided with documentation to support the evaluation of these processes.
Rating
Met
Findings
-

Action 8.09
The workforce uses the recognition and response systems to escalate care
Evidence Reviewed
Staff were able to describe the systems in place to escalate care consistent with GCPH policy and procedure. Documentation as per 8.01.
Rating
Met
Findings
-

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
Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. GCPH provides Basic Life Support training annually as it is a mandatory requirement for all clinical staff.
Rating
Met
Findings
-

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
Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. GCPH provides Basic Life Support training annually as it is a mandatory requirement for all clinical staff and offer Advanced Life Support training for those staff that require this additional competency.
Rating
Met
Findings
-

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

Evidence Reviewed
All GCPH patients are screened on admission to identify any psychosocial/delirium concerns, with management plans developed and monitored for patient safety. GCPH has processes in place to ensure timely referral to mental health services for patients whose mental state has acutely deteriorated. The requirements of Advisory AS 19/01 have been met.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Evidence Reviewed
GCPH policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to assessors. Assessors reviewed Transfer of a Patient - Inter-Hospital 2.49 July 2022 and Transfer (Intra-Hospital) of a patient from the Emergency Department 2.55 May 2021.
Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable