National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Initial Assessment Report

The Geelong Clinic

St Albans Park, Victoria

Organisation Code: 220997
Health Service Facility ID: 101047
ABN:85 006 405 152
Assessment Date: 30-31 August 2023

Accreditation Cycle: 1

Contents

Introduction

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

ACHS is approved to accredit the following standards

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

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

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

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

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

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

The Commission works in four priority areas:

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

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

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

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

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

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

Rating scale definitions

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

Rating	Description
Met with recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

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

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

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *National Safety and Quality Health Service Standards 2.1 Short Notice Assessment*. This approval is current until 31st December, 2024.

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Ann Cassidy	Yes
Assessor	Kevin Freele	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for The Geelong Clinic. A final assessment will be required before the accreditation determination can be made.

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

The Geelong Clinic underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 30/08/2023 to 31/08/2023. The NS2.1 Short Notice Assessment required two assessors for a period of two days. The Geelong Clinic is a Private health service. The Geelong Clinic was last assessed 22/10/2019 – 23/10/2019.

PICMoRS was used to conduct this assessment. 75% of available time was spent in operational areas during this assessment.

The Geelong Clinic (TGC) undertook a Short Notice Assessment against the National Safety and Quality Standards (Second Edition), conducted by the Australian Council on Healthcare Standards on Wednesday, the 30th through to Thursday, the 31st of August . This assessment was conducted on site by two assessors.

The TGC staff were well prepared for the assessment with appropriate evidence available for all actions. High-risk scenario testing, related to these standards and risks found on the organisation's risk register, were woven into discussions with staff during interviews and demonstrated how well the organisation managed to mitigate these risks. Examples include the prevention and management of alcohol and or illicit substance consumption whilst on day leave and when a patient is absent without leave. Assessors assigned the achievement of Met ratings for all actions with two Met with Recommendation (MWR) ratings for actions within Standard 1 - Governance, and Standard 2 - Partnering with consumers. Not applicable ratings were verified for all actions within Standard 7 - Blood and Blood products and in five actions in Comprehensive Care that related to End-of-life care and seclusion. A number of suggestions have been made within the Standards that seek to strengthen existing systems and processes.

The Assessment team used the PICMoRS methodology coupled with patient journeys, file reviews, process reviews, and staff and patient interviews, to elicit information related to the applicable actions and were able to confirm the following processes, systems, and practices.

TGC is currently operating within an environment of change with a newly appointed GM / DON and a Quality and Complaints Manager. Environmental factors, post-Covid affecting the TGC's ability to recruit and access specialist roles within the workforce and changes made to the way in which communities can access mental health care, are having an impact on the business. Healthscope Corporate has a sound understanding of the issues, risk and challenges facing TGC, and is active in retaining and building on existing service provision.

The clinical governance systems developed at Healthscope and implemented at TGC are robust and effective. The systems ensure that patients, staff, executives, and governing bodies are focused on good clinical outcomes and areas of potential improvement. The clinical workforce is supported to use the best available evidence. Variations to care are monitored through a range of quality assurance activities and outcome performance metrics. The effectiveness of the quality improvement framework at TGC is a priority and much work has been achieved in this regard. More attention can be given to ensuring the quality improvements made in the following audits achieve an acceptable level of improvement. If change is not within the levels of tolerance, then a higher level of action is taken.

TGC's commitment to training and skills development, mentoring, capability building, and access to supervision was clearly evident for all members of the workforce. Credentialing and the assignment of scope of practice was well established for all health professionals. The completion of mandatory training and performance appraisal reviews to the targets set are areas for improvement. This is related to the above comment on setting what level of improvement is acceptable and what is not acceptable.

The environment at TGC is welcoming and has a relaxing atmosphere which is helpful for patients to feel "at home". The building is well maintained. TGC's approach to the identification and management of occupational violence is person-centred, situational, and tiered to the response required, however, were not in alignment with Healthscope policies. All actions within this standard are Met, with action 1.30 Management of aggressive events rated as MWR.

TGC has developed and implemented an impressive culture of effectively working in partnership with consumers to achieve the best care and outcomes for the consumer. For many years, TGC has employed consumer representatives or consultants, as the role is now called. The consumer consultant role has recently expanded from one to three consultants. It is evident that amount of commitment and partnership with consumers that can be seen in the TGC Consumer Engagement Plan. Consumer-centred care principles were evident in all wards, consumers and staff spoken with during assessment. Patients interviewed described to the Assessment team their experience and involvement in care decisions, and that staff were respectful of their culture, beliefs, choices and values. All actions within this Standard were rated as Met, with action 2.04 (c) consent rated MWR.

Clinical governance and quality improvement systems that support the prevention and control of healthcare associated infections and improve antimicrobial stewardship (AMS) across TGC are evidenced. The IPC system at TGC is well supported by externally contracted infection and prevention consultants and well-established clinical governance processes and systems. An extensive range of policies is available to the workforce and mandatory training requirements identified and provided. Infection-related data is reported, monitored, investigated and improvements made where required. It includes the use of surveillance data to ensure the appropriate prescribing of antimicrobials to reduce the development of resistant organisms.

Personal protective equipment (PPE) is readily available, and staff are provided with appropriate training and education. Facilities are well maintained and kept to a high standard of cleaning, confirmed by cleaning audits, schedules, and patient feedback. Action is taken to reduce the risks of healthcare-associated infections as evidenced by the increased focus on increasing participation rates in the staff vaccination program (which links into the Australian Immunisation Register), the Respiratory protection program (fit testing), and screening for infection risks. All actions within this Standard are rated as Met.

Appropriate governance systems are in place to support the safe and effective use of medicines that incorporate the elements of the medication management pathway and meet the patient and client profile across TGC services. Governance of the medication management system is overseen by TGC Medication committee. Patients and carers, where appropriate, are actively engaged in their medication therapeutic plan across their care continuum. Medication management is supported with a number of appropriate policies, procedures, and strategies to ensure clinicians are competent to safely prescribe, dispense, administer appropriate medicines, and monitor their use. Training, education, and specific medication competencies are developed and implemented. Medication rooms and documents demonstrated appropriate, safe, and secure storage of medicines. High-risk medicines have been identified, and discussions with staff demonstrated a good understanding of safe practices when storing, prescribing, and administering these medicines.

Improvements to the system were noted, and these included initiatives to improve medication storage and safety, the provision of enhanced consumer information, the strategies to reduce medication administration errors, and the enhanced training and development of staff competencies for the administration of Ketamine in psychedelic therapy. A suggestion has been made to review the committee's membership to provide greater clarity around role and responsibilities and support TGC to optimize medications for patients and mitigate harm from incidents. All actions within this Standard were rated Met.

TGC provides a patient-centred model of care which supports the journey of recovery and relapse prevention for consumers living with mental health-related issues and problems. This model aligns with both the Partnering with Consumer Standard and Comprehensive Care Standard. Processes and systems support a partnership approach among clinicians, patients, and their families in the planning, development, delivery, and evaluation of care and treatment provided. It is evident from patient and family feedback that they feel involved in their care journey, to the extent they choose. Care is well coordinated by the various multidisciplinary team members with the patient' goals of care and healthcare need being the primary focus. Risk screening is holistic, looking at physical health, mental health, and psychosocial needs of each patient as an individual. Screening is completed according to policy and closely monitored through the governance and committee structures. Action plans are developed, where required, to ensure areas of concern are reviewed and interventions implemented.

The pre-admission assessment and screening process ensures the identification of risks and suitability of the in-patients and day programs for patients. Where risks or potential issues are identified, alternative services and care provider options are provided. Processes are in place to ensure Advance Care Plans are identified and documented. Risk and screening assessments are used to develop the care plan, and care plans are regularly reviewed in partnership with patients and, where appropriate, their families. Completion of care plans are monitored and reported through the governance structure. Suggestions have been made to strengthen existing systems that relate to the review of the referral systems, training requirements, and the Health scope comprehensive risk sheening tool and associated risk management options. All actions within this standard are rated as Met with five actions 5.16, 5.18, 5.19. 5.20 and 5.36 rated as Not Applicable.

There are policies and processes that ensure good communication between clinicians and the identification of patients receiving the correct medication or procedure. Clinical handover is done well and the bedside handover process is respectful towards the patient and engages the patient in their own care and wellbeing. The clinical medical record is paper based, which can be an area for future improvement. Feedback from patients and families indicate that they are well communicated with and involved in care and can raise issues of concern, if necessary. All actions within this Standard were rated as Met.

All actions within the Blood Management Standard were verified as Not Applicable.

The clinicians at TGC are well-trained and competent in the identification and management of patients who are experiencing deterioration in their mental state or physical wellbeing. Between the flags, formats are used to monitor vital observation, and discussions with staff demonstrate knowledge of the tiered-escalation approach. The patients admitted to TGC are voluntary and in general not acutely unwell, however, the staff are ready to identify and respond appropriately if the situation arises. Patients, carers, and families can escalate their concerns directly with staff or alternatively via the REACH system. All actions within this standard are rated as Met.

Summary of Results

At The Geelong Clinic's Organisation-Wide Assessment, two Actions were rated Met with Recommendation across eight Standards. The following table identifies the Actions that were rated Met with Recommendation and lists the facilities to which the rating applies.

Summary of Recommendations Subject to the Final Assessment

Facilities (HSF IDs)	NS2.1 Short Notice Assessment 30/08/2023 - 31/08/2023	
	MwR	NM
The Geelong Clinic - 101047	1.30, 2.04	

Final Assessment Requirement

As there are actions rated Met with Recommendation, there is a requirement of the Australian Commission on Safety and Quality in Health Care (ACSQHC) that the health service organisation is given a period of remediation and the Met with Recommendation actions undergo a final assessment within 65 business days of the initial assessment.

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

Sites for Assessment

The Geelong Clinic

Site	HSFID	Address	Visited	Mode
The Geelong Clinic	101047	98 Townsend Road ST ALBANS PARK VIC 3219	Yes	On Site

Contracted Services

The following contracted services are used by The Geelong Clinic.

Provider	Description of Services	Verified During Assessment
TPS Air and Regal Air	Central Air Conditioning System	Yes
Barwon Health	Biomedical Engineering	Yes
Firewise	Fire & Safety Services	Yes
Cabrini Linen Services	Laundry/Linen service	Yes
Barwon Health	Medical Library	Yes
Peak Pharmach Bellarine Village	Pharmacy Service	Yes
Veolia- Corporate contract	Waste Management	Yes
EcoLab	Chemical Supply	Yes
Clifford Hallam	Medical/Pharmacy supplies	Yes
HICMR	Infection Control Consultants	Yes
Bidvest	Food Supplies	Yes
GRS (Geelong Refrigeration Service)	Coolroom & small air conditioners	Yes
Mr Electrics	Electrical services	Yes
Buck Plumbing	Plumbing services	Yes
TMS	Automatic doors	Yes
Leader Phones	Telephones	Yes
Perfect Vision	Nurse Call/Security	Yes
Combitech	Catering equipment	Yes
City of Greater Geelong	Waste Collection - general	Yes
Gen Care	Generator service	Yes
Selkirk Hospital Services	Pan washer service	Yes
Boiling Billy	Hot Water Boiler	Yes
Jim's mowing	Gardening	Yes
Geelong Locksmiths	Locksmith	Yes
Acacia Pest Control	Pest Control	Yes
NPS	UPS Uninterrupted Power Supply	Yes
Air Vac Engineering	Medical Vacuum Pumps	Yes
Total maintenance Solutions	Automatic doors	Yes

The Geelong Clinic has reviewed these agreements for the listed services in the three years preceding this assessment.

Standard 1 - Clinical Governance

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

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Comments	
The Geelong Clinic (TGC) Clinical Governance Plan 2022-2023 was viewed, and it is linked to the OneHealthscope 2025 strategy. TGC has a long history of stable leadership, however, the General Manager / Director of Nursing (GM / DON) leadership was changed two weeks prior to the short notice assessment. The structures and processes to ensure the safe and effective delivery of care is well embedded within the culture of TGC. The Clinical Governance Plan 2022-2023 has been endorsed as a Consumer Approved Publication. Extensive KPI reports are sent to Healthscope monthly which covers safety, quality, financial and patient flow, and patient satisfaction data. The appropriate Healthscope committee reviews and monitors TGC progress against the KPI.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
The governing body, Healthscope, has developed a Reconciliation Action Plan and it has been ratified by Reconciliation Australia. TGC has developed a very well thought out and actioned Aboriginal and Torres Strait Islander Engagement Plan (2022-2023). Significant activities of acknowledgment of country, community engagement, communication with staff, and implementing a welcoming environment has been achieved.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
The clinical governance framework at TGC links to the OneHealthscope 2025 Strategic Plan. The Clinical Governance Plan has been endorsed by the Healthscope Board (2019), and the plan was reviewed in 2023. The structures within the clinical governance framework drive safety and quality improvements at TGC. The Heads of Department committee and the Quality committee oversee and monitor continuous quality improvements at the service. Reporting on improvements and issues up to Healthscope senior management ensures high level awareness of performance at TGC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.04	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
There was evidence in policies and staff discussions confirming that TGC had procedures in place to monitor and report the effectiveness of quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
Minutes of the MAC and Heads of Department meetings showed that decisions regarding the business of TGC considers the wellbeing of patients and all business decisions aim to improve the quality of care provided. The recent expansion of beds at TGC had consumer input and focused on improving the scope of services offered to patients. The introduction of the Ketamine therapy is another example of a business decision that considered the quality of health care for patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
Medical, nursing, allied health, and managerial leaders were observed to actively support clinicians and were readily available for clinical advice or direction. Staff were aware of their safety and quality responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation, and jurisdictional requirements	
Comments	
Policies and procedures are reviewed and updated in accordance with Healthscope policy on policy maintenance. Any change in policy or procedure is notified to staff and raised at staff meetings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Comments	
TGC has systems and processes to report to management on safety and quality measures. There are good quality initiatives and tracking of the quality activity outcomes. Reporting lines within TGC and up to Healthscope are well established. The Assessment Team noted that many of the outcome measures on quality activities / audits were not reaching the organisation's internal target. The activity would be re-audited and remain below target. There is an opportunity for management to reduce the tolerance of variance in the results of quality / audit activities. Consumer consultant at TGC has the opportunity to attend the Quality committee to review quality performance and outcomes.	
Suggestion(s) for Improvement	
Develop a process where key performance indicators on safety and quality measures are escalated to reduce tolerance of outcome variation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.09	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	
There are guidelines on the monthly reporting timeframes of quality and safety performance by the GM / DON to the governing body. Reports on occupational safety audits, quality activities, and operational issues are reported at the Heads of Department meetings on a regular basis. The MAC, nursing, and allied health committees also receive reports on quality and safety standards.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Comments	
Healthscope and TGC have an established and effective risk management system. Risks on the risk register are risk-rated and are regularly monitored by senior management at TGC and at Healthscope corporate. As soon as a high risk is identified, the senior management at TGC and Healthscope are notified. Staff are aware of risks in their workplace and know how to identify risks and how to escalate the risk. Environmental risks, such as ligature risks, are a high priority at TGC. Regular Psychiatric Environmental Risk Tool (PERT) is conducted to identify and rectify any risks within the facility. There are plans in place for the management of internal and external emergencies. Mock fire drills are scheduled on a regular basis and results of the drill are recorded.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Comments	
Policies and procedures at Healthscope and TGC on incidents give guidance on the management of incidents. Incidents are registered on RiskMan. Investigation into the incident is timely and where changes can be made, they are implemented. A recent example of a deep dive investigation into medication errors resulted in bedside dispensing of medications no longer in practice. Instead, all medications are now dispensed at the medication room window. The incident rate of medication errors has sharply decreased. Information is given to patients and relatives about how to raise an incident concerning care. All incidents are trended and are included in the monthly management report to Healthscope. Incident trends are also tabled at key TGC committees.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
Open Disclosure training is a mandatory training course for staff. The compliance rate meets expectations. When the open disclosure process is used, it is reviewed to for areas of improvement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
Patients and families are provided with information on how to make a complaint or how to seek additional help regarding a concern. Complaints can be in written form or verbal. All complaints are entered into RiskMan. The YES patient survey is conducted quarterly and information from the survey is used to make improvements in the quality of care provided. Results of the survey are tabled at staff meetings for staff to be aware of the feedback from patients completing the survey.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	
Policies and procedures guide staff on the management of complaints. Information is given to patients and families on how to make a complaint, which can be in writing or verbal. At the weekly patient community meetings, patients can raise issues of concern or suggested improvements. The staff then post a list of the concerns raised and indicate the resolution of the issue or what cannot be resolved. The majority of complaints are resolved immediately by the nursing staff. The consumer consultant can be involved in the management of the complaint if the patient wishes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
TGC has a good understanding of diversity of the patients using its services. The clinical programs offered meet the needs of young people, the elderly, those with eating disorders, people with drug and alcohol problems, support for first responders and veterans with post-traumatic stress disorders, as well as people who have depression, anxiety, and severe mental illnesses. The in-depth intake assessment process identifies those who may be at a higher risk of self-harm than the facility can safely manage. Those people are referred to a public mental health service who can manage more acute mental illnesses. Admitted patients who need closer nursing observation have their bedroom near the nurses station and their observation level is escalated whilst their risk of harm is of concern.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Comments	
Healthcare records at TGC are paper based. Clinical records are kept at the nurses' station and available for quick access by staff. At the bedside handover, the clinical record is taken to the patient's room. All staff are trained in the management of the clinical record and are aware of legislative requirements concerning the confidentiality, storage, and retention of the records. Health records are regularly audited for completeness and results are tabled at Heads of Department committee and at the Quality and Safety committee. Admission records are entered into WebPas system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
TGC uses the national patient and provider identifiers and standard terminologies in My Health Record system, which meets the requirements of AS18/11.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
TGC has processes to ensure the accuracy and completeness of information uploaded meets the requirements of AS18/11.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student, or volunteer members of the organisation	
Comments	
The orientation process for all staff employed at TGC has been reviewed, with improvements made and feedback from staff positive. The orientation program is comprehensive. The orientation checklist has recently been reviewed and improved across all treatment streams within TGC. The Quality and Complaints Manager provides an orientation to the new psychiatric registrars coming to work at TGC. Contractors receive a site orientation and information regarding safety issues around the facility. Staff spoken with are aware of their roles and responsibilities regarding safety and quality.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20		
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training		
Comments		
Healthscope and TGC have determined a range of mandatory training courses all staff must complete at commencement of employment and at other times during the employment. The eLearning system records and track employee training record. TGC employs a nurse educator to assist in ongoing nurse training. The training records for VMOs who are also employed in the local public system is available to TGC. Improvement in having staff complete their mandatory training courses is progressing but further improvement can be achieved. TGC have an action plan to address improving staff completion rates to meet their internal targets.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Comments	
Healthscope has developed and implemented their Reconciliation Action Plan. TGC has developed and implemented the Aboriginal and Torres Strait Islander Engagement Plan. Cultural awareness training is mandatory for all employees. The Aboriginal and Torres Strait Islander Engagement Plan has defined strategies and actions to improve the cultural awareness and cultural competency of the workforce. The Plan was developed in collaboration with staff and the local Aboriginal community in Geelong. TGC meets the requirements of AS18/04 for Action 1.21.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22		
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system		
Comments		
Policies and procedures at Healthscope and TGC give direction on the requirements of annual performance review process. Staff are reminded via an email message that their performance review is coming due. Supervisors conducting performance reviews have been trained. The performance review process includes the future training and clinical skill development that the employee identifies and agrees to work towards. The training needs are then included, where possible, in the organisations training calendar. Due to changes in senior staff, annual performance appraisals are behind schedule and TGC have an action plan in place for the appraisals to be conducted in a timely manner to meet the organisations internal targets.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Comments	
Credentialling is well managed at TGC. The credentials and scope of practice for VMOs are endorsed and approved at the Medical Advisory Committee. Medical credentialing is valid for three years and initial temporary credentialing for 120 days. Nursing, allied health, pharmacy, and occupational therapists are checked for their annual APHRA registration. There is a policy on the introduction of new clinical intervention or technology. It outlines the procedure that the proposed new intervention must be approved by the Heads of Department then approval by the MAC and then approval by Healthscope corporate. Any new intervention or technology is often first discussed in clinical supervision sessions, which all staff engage in.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	
Prior to employment, the credentials and training evidence are checked and verified. APHRA registration, and any restrictions to practice, is checked. Annual checks on APHRA are done to ensure the employee is currently registered. A recent audit at TGC of the eCredential system used by VMOs at Healthscope was 100% compliant to requirements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	
A key component of the orientation program for all staff is to educate staff on their roles and responsibilities for safety and quality. The staff spoken with were aware of their responsibilities regarding the safety of the environment, safety of patients, and their role in quality assurance. The staff interviewed were able to speak to and were proud of the quality improvements made in their program / ward. The WHS representative role has been vacant for a period of time, but a nurse has now volunteered to take on the role and will be attending training soon.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
All Allied Health staff have supervision, either by an internal senior clinician or by an external senior clinician. Nursing staff have huddle sessions on topics on areas of clinical interest, and this is also an opportunity for supervision. Nursing clinical supervision is available as required. The Consumer Consultant has external supervision for his role. The VMOs have Professorial rounding and peer review sessions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways, and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
Clinicians have access to best practice guidelines, clinical literature articles, and relevant mental health practice standards. Supervision and peer review assist the clinician in learning about and implementing current clinical practice guidelines. The Australian Commission's advice on the implementation of the Delirium Clinical Care Standard was circulated to staff when it was released in 2021. When staff attend conferences, they will bring back to TGC new ideas and clinical practices they have learned about at conference. A good example is the detailed planning, training, and policy and procedures development that was put in place prior to the introduction of the Ketamine clinic at TGC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Comments	
Senior staff at TGC meet regularly with the other Healthscope mental health services across Australia to compare, benchmark, and learn from each other about clinical outcomes. A suite of patient outcome measures is used, such as HONOS, to monitor clinical progress and variation. The transcranial magnetic stimulation (rTMS) program uses patient self-report tool, IDS-SR, to gauge patient satisfaction and sense of improvement after rTMS sessions. The Professorial rounding enables clinicians to take part in the clinical review of their practice.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices, and other infrastructure that are fit for purpose	
Comments	
The design and layout of TGC has been thoughtfully planned to meet the needs of the patients. Even though the original facility was built as a general hospital, over the years, the re-design and re-furnishments have been planned to meet a mental health service environment. The majority of patient rooms are for single occupancy and the anti-ligature fixtures reflect best practice design. The building, plant, and equipment sighted by the Assessment Team are fit for purpose. Where improvements in space utilization can be improved, for example in the ECT, TMS and Ketamine procedure clinic, adjustments have been made.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30		
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required		
Comments		
The nursing staff conduct risk assessments on patients throughout the day. This gives staff some foresight into potential escalating behaviours, and de-escalation techniques can then be employed. Carers and families are encouraged to inform staff if their relative is becoming more unsettled. There are no seclusion rooms or use of physical restraints at TGC. The patient's care plan lists events or incidents which might trigger an escalation in his / her behaviour. This knowledge assists the staff in developing with the patient strategies to minimise risky behaviours.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	All	**Comment:** Healthscope have two policies that refer to the identification, prevention and management of Occupational Violence and Aggression (OVA). Within the policy documents, there is a requirement for each site to have a Code Grey response, OVA environmental audit, and staff training that is aligned to their level of risk exposure. During the assessment, it was noted that the designated WAVE training is provided to staff and compliance with the online training module(WAVE 1) is high; however, staff participation in the face-to-face training (WAVE 2) and training for the first responders (WAVE 3) was well below internal requirements. The annual OVA environmental audit has yet to be completed. TGC does not have a Code Grey response. A Code Black response is utilised for an aggressive event which triggers a police response. **Recommendation:** To: 1. Review TGC's compliance with Healthscope OVA policies with specific reference to staff training, OVA environmental auditing requirements, and the initiation of a Code Grey response. 2. Develop an action plan with assigned responsibilities and associated time frames, to address gaps identified within the review. **Risk Rating:** Low

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
The signage and directions at the front of the clinic and internally give clear directions and are easy to read. All patient rooms are numbered with large letters. Directions to each of the wards are sign posted.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
The visiting hours during the day and in the evenings for admitted patient by their family, or friends is generous.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
TGC has a welcoming environment for Aboriginal and Torres Strait Islander people. There is a large Aboriginal painting in the front foyer. It is planned to engage a local Aboriginal artist to paint another large painting. A map depicting the lands of Aboriginal and Torres Strait Island people is also planned. The Aboriginal and Torres Strait Islander people focused charter of rights is displayed in the main foyer. Administration staff have been trained on why and how to ask the question on admission about the person's cultural heritage. There are Aboriginal and Torres Strait Islander drawings and paintings throughout the facility. TGC meets the requirements of AS18/04 for Action 1.33.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
TGC has at the forefront of their actions, the safety of consumers and the quality of care provided to consumers whenever a policy or procedure is developed and implemented. The Consumer Consultant is engaged with TGC management to minimise risks to consumers. The Consumer Consultant has a role in the orientation of new staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	
TGC has a long history of partnering with consumers dating back to 2003 and the appointment of a consumer representative in the eating disorder program. From that time, TGC has monitored, made improvements in processes, and implemented strategies and policies to improve the engagement with consumers. Today, TGC employs three consumers in consultant roles across several of their clinical programs, in particular the Drug and Alcohol rehabilitation program, the eating disorder program, and the PTSD program. The consumer consultants provide feedback on their roles to the Quality and Complaints Manager who reports to the Heads of Department committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
The Charter of Healthcare Rights is posted at the front foyer of the building. Information on consumer rights and responsibilities is available in the welcome pack given to consumers. On admission, consumers sign the Ellis disclaimer form and a Release of Information form. Audits are conducted on consent forms resulting in 100% compliance. Consent is given prior to ECT, TMS, and Ketamine therapies. The process for gaining written consent to have the consumer's photograph taken at admission is not consistently applied as per TGC policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.04		
The health service organisation ensures that its informed consent processes comply with legislation and best practice		
Comments		
The Geelong Clinic (TGC) has good procedures to obtain written consent for admission and for release of information. Evidence was sighted of the Ellis Disclaimer form, the Release of Information form, ECT, TCM, and Ketamine consent forms. Consent forms are audited as per audit schedule. Financial cost of the inpatient stay is explained at admission and there is informed consent given by the patient. Compliance with AS18/10 is achieved.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	All	**Comment:** Consumers' written consent for their photograph taken at admission does not consistently follow the Healthscope policy 9.15. **Recommendation:** Implement processes and training to ensure consumers give written consent at admission for their photograph to be taken. **Risk Rating:** Low

ACTION 2.05	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
Assessment of the consumer's capacity to make their own decisions is assessed by staff on a regular basis. The risk assessment done by nursing staff and the consumer's treating doctor informs the staff about any changes in the person's capacity to make informed decisions. If the capacity to make informed decision diminishes, communication with family members occurs to discuss options of care. The staff spoken with could not recall a patient who was admitted with Advance Care Plans.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
Policy and procedures are implemented for staff to work in collaboration with the patient to develop their care plan. The care plan sets out goals which the patient decides are what he / she wants to achieve and steps to achieve the goals. The care plans are signed by the consumer. The care plans are reviewed with the consumer frequently and goals or actions adjusted as treatment progresses.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.07	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Comments	
TGC has demonstrated that the service culture embeds the principles of person-centred care. This was evident when the Assessor team spent time on the wards talking to staff and to patients. The discussions with the patient during the bedside handover about the care they have experienced, their plans for the day, and any concerns the patient might have demonstrated the partnership with the patient in being involved in their own care. Staff have received training and in-service education on person-centred care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.08	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
The staff can use the services of interpreters when needed, but this has rarely been required. The wide range of in-patient and day patient treatment programs offered by TGC meets the diverse needs of the people who might use the services offered.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.09	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
All pamphlets and literature designed for consumers is reviewed by the consumer consultant and the publication has the Consumer tick of approval on the back page. Consumers are given a recovery book which is co-written by consumers and staff aimed to assist the consumer on their recovery journey. The language used in the consumer literature is clear and concise. The consumer and family are encouraged to ask for more clinical information if they wish to learn more about a specific therapeutic treatment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families, and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Comments	
In discussions with clinicians and observing staff and patient interactions, it was evident that information was given to patients in a way that was easy to understand and met the patients' needs. Patients who were interviewed by Assessors also supported that they felt information was provided to them in a manner and format they could understand. The recovery booklet is a good example of providing information to patients whilst in hospital and on discharge to assist them in their recovery journey. Patients can be offered to attend the day programs after discharge for further clinical care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Comments	
The consumer consultants have membership on the Quality, Work Health Safety, and Infection Control committee. The consultant can also attend the Heads of Department committee. The consumer consultants work closely with the Quality and complaints Manager in the design and evaluation of consumer satisfaction measures. The consultants work closely with patients in groups and one-on-one discussions. From this, the consultants can raise with appropriate staff any potential issues that may be arising with patients so prompt discussions can occur to de-escalate the concerns of the patient(s).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement, and evaluation of the organisation	
Comments	
All three consumer consultants have gone through the orientation process upon employment. The Assessor spoke with one of the newly appointed consultant consumers about the orientation and supports he experienced. He stated the support given to him was very good and appreciated. The orientation program in general was good but the looking at policies and procedures online was a bit arduous. The consultants have access to external supervision. Further support and education about committee meeting processes would assist the consumer consultants to be more comfortable in attending committee meetings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
TGC's Consumer Engagement Plan 2021-2024 is an impressive strategic plan to further enhance and embed consumer engagement. There are strategies and actions in the Plan addressing Aboriginal and Torres Strait Islander patients and community healthcare needs. TGC continues to build its relationships with local Aboriginal and Torres Strait Islander elders, Aboriginal Medical Service Centre, and attendance at significant cultural events in the community. TGC meets the requirements of AS18/04 for the Action 2.13.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
The consumer consultants at TGC work with other consumers to share their experiences and knowledge of their own recovery journey in order to educate and help other consumers on their recovery pathway. The lived experiences of the consumer consultants are shared with staff at in-services training and orientation sessions.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
Assessors reviewed infection prevention and control (IPC) and antimicrobial stewardship (AMS) documents (produced by both Healthscope Corporate and HICMR) 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 AMS and preventing and controlling healthcare-associated infections. The Geelong Clinic (TGC) IPC systems are supported by both HICMR and external IPC consultants, who are onsite one day per fortnight, and a contracted clinical pharmacist. TGC has access to a clinical microbiologist and ID physician. A suggestion has been made to give consideration to the introduction / assignment of an infection control Link nurse or portfolio responsibility to a registered nurse to support the onsite application of the IPC system at the direct care level.	
Suggestion(s) for Improvement	
Consider the introduction / assignment of an infection control Link nurse or portfolio responsibility to a registered nurse to support the onsite application of the IPC system at the direct care level.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
Operational and governance oversight is through the Quality and Safety Committee (Q&SC) and Medical Advisory committee (MAC), respectively. Each has documented roles and delegated responsibilities and provides reports to Healthscope Clinical governance committees. Terms of Reference describe their responsibilities of monitoring and improving infection prevention, antibiotic stewardship, the effectiveness of the surveillance systems, and workforce training. These have recently been reviewed to provide greater transparency and accountability for the Governance of the AMS program. The HICMR TGC IPC Management Plan is based on the risks associated with the services offered and compliance with the NSQHS standards second edition. Progress to the plan is demonstrated. The IPC online learning modules are constructed into mandatory, role-specific requirements, and general professional development. It commences at orientation and continues across the employment period. Records of attendance are maintained at a service and unit level, with rates of attendance in the top percentile. Non-clinical workforce participation and compliance rates for role specific designated training is around 99-100%. Food services staff have all completed food safety training. During the assessment it was unclear as to what IPC training is required for the medical workforce. AMS orientation and ongoing training is primarily provided to the medical staff at induction, clinical rounding, and at point of care.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources	
Comments	
There is a comprehensive schedule of auditing for IPC and antimicrobial stewardship systems. The HICMR Risk assessment program covers all areas and aspects of TGC and monitors compliance with IPC policies. Audit results are provided to the executive and individual units, and aggregate data is provided through TGC clinical governance structure. IPC and AMS are discussed at the relevant committee meetings, and strategies are identified to improve performance where gaps are identified. External benchmarking occurs through participation in ACHS clinical indicators program and VICNISS. TGC is not an outlier in either program. Incidents entered into the Incident management system (Riskman) are reviewed and a hierarchy of control approach is applied in the consideration of corrective actions where indicated. The number of Infection related incidents is relatively low and primarily relate to Covid 19 notifications.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
The engagement of consumers is primarily at the individual level, where specific information is provided as part of the care planning process, and across the services where consumers are consulted on matters pertaining to IC. A qualitative patient survey was undertaken on the impact of Covid on admissions in 2022. Feedback was noted. Consumer consultant rounding activities incorporates a series of questions relating to IPC. At the time of the assessment, the results for the June 2023 period were not available. Information is available to patients, carers, and families in a format that is easily understood. A number of communication approaches are utilised and include general and specific information on the Healthscope website, targeted disease specific information brochures and handouts, awareness posters, and direct conversations at point of care. Patients and staff interviewed by members of the Assessment Team were able to describe the actions taken to involve and inform them about infection prevention and control. Awareness posters, such as the prevention of transmissible diseases and the importance of hand hygiene, were visible across the service.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
TGC 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 clinical governance structure and general staff communications. During the assessment, it was noted that the AMS performance indicators were below internal performance targets, and a Quality initiative project has been initiated to respond to the variances across the indicators collected. TGC is encouraged to continue to engage with clinicians to improve compliance with evidence-based guidelines. Hospital-acquired infection (HAI) rates for a blood stream infection (as reported by VICNISS) has remained relatively consistent over time. Neither SAB events nor outbreaks have been reported. TGC is compliant with Advisory AS20/02.
Suggestion(s) for Improvement
Performance dashboards be developed to visually represent the outcomes / results of surveillance activities, compliance audits, and IC and AMS performance indicators. This would enable better governance oversight and assurance of the compliance with and effectiveness of the IPC and AMS systems as a whole.

Rating	Applicable HSF IDs
Met	All

ACTION 3.06	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws	
Comments	
The review of infection control documents indicates that processes consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for standard and transmission-based precautions are in place. The Assessors noted that signage and other resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Comments
Organisational-wide policy and processes for the management of organism-specific risks, that are consistent with jurisdictional and Public Health advice (including prevalence in the community), were evidenced. Healthscope and HICMR provide alerts to TGC on any pandemic management practices, local disease outbreaks, and the DoH safety notices. Standardised precautions are applied for all persons, irrespective of the care setting across TGC. PPE stations and outbreak kits are available for staff to access. Risks are regularly reviewed at the various communication forums for staff and patients. The Healthscope risk register incorporates a number of risks relating to the management of organism-specific risks at TGC. Controls in place are considered effective and the risks are classified as stable. Staff have been trained in the use of personal protective equipment. Donning and Doffing and Respiratory fit testing is required for staff working in high-risk areas. Standard and transmission-based precautions are regularly audited with high compliance and participation rates.

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	
Clinical handover, transfer of care, and discharge processes include the requirement for documentation and communication of infectious status. Brochures, posters, Internet sites, and pre-admission information are utilised to advise patients, carers, and visitors on infection control and management processes in place.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.08	
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care	
Comments	
Procedures and training programs are available for implementing standard and transmission-based precautions and all staff, including non-clinical staff, are provided with education appropriate to their role. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Facilities are designed to effectively manage infection risks and environmental management and cleaning practices are consistent with policy. TGC facilities, patient, and staff workflows have been adapted to control the environment to effectively manage infection risks. Access to single patient care rooms reduce transmission.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.09	
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection	
Comments	
Communication of a patient's infectious status is included at all transfer of care / handover points. Consumers accessing TGC services are screened for infection risks at the first point of contact / admission into the service. Identified risks are entered into the patient's administration system (WebPas) as an Alert. Patients, carers, families, and visitors are alerted to precautions that are required with ACSQHC A3 posters describing the required precautions at the entry of patient rooms.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance	
Comments	
The Hand Hygiene program is consistent with the current National Hand Hygiene (HH) Initiative and jurisdictional requirements. TGC has access to a limited number of external Gold Standard Hand Hygiene auditors. Regular compliance and observational audits are undertaken, and performance reports are provided to staff and through the governance structure. TGC's current aggregated compliance rates are at 80.5%, which is trending below the national rate for a number of audit periods. The completion of Hand Hygiene training for the workforce is at 94%. Performance against targets is communicated to each department and the various safety committees. TGC is compliant with the requirements of Advisory AS20/01.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11	
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	
The ACSQHC risk matrix has been utilised to determine clinical practices where Aseptic technique is required. Clinical practice guidelines describe the required aseptic technique for those procedures performed across TGC, which are typically simple wound dressings and IV insertion for ECT. The clinical workforce is trained in Aseptic techniques (ANTT) at the commencement of their employment and reassessed. Competency training and assessments are utilised for a limited number of clinical practices that require aseptic technique in the inpatient setting. At the time of assessment, 98% of staff had completed their requisite training.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
TGC has appropriate clinical practice guidelines in place for the management of Invasive devices. The use of invasive devices is limited to the insertion of Peripheral Intravenous Catheters for the administration of ECT by credentialed anaesthetists. Observational audits on the insertion of PVIC were not sighted during the assessment. Education and competency assessment programs are in place to support staff in the safe use of invasive devices. Compliance is high and the rates of hospital acquired infections are very low.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Comments	
Cleaning Practice Guidelines, Standard operating procedure, schedules and check lists are in place. Regular auditing and performance reports are made available through the governance structure. Cleaning audit reports provided to the Assessors indicated that cleaning standards are consistently at or above benchmark targets. The Assessor team supports the plan to incorporate additional environmental cleaning outcome validation and increased objectivity into the auditing process. Observational audit conducted by the Assessment team over the course of the assessment indicated that patient-related equipment utilised for observations were not cleaned between uses. Feedback was provided to the staff during the assessment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.14	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	
Comments	
TGC has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen. Assessors were able to validate that new product, equipment, and building refurbishments are formally reviewed and assessed for infection-related risks. Maintenance is both scheduled and responsive to failure. Reports are provided to the IPC Committee. Waste is segregated at the point of generation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers, and patients	
Comments	
There is a comprehensive workforce immunisation program in place that complies with jurisdictional policy and national guidelines. Immunisation status is captured during the recruitment process. TGC has just completed the annual influenza vaccination program with 86.3% of staff immunised. 100% of the workforce are compliant with the third COVID-19 vaccination requirement. TGC has commenced the process of reporting vaccines into the Australian Immunisation Registry and have embarked on a quality improvement initiative to increase the workforce's participation rate in vaccine preventable diseases. The project is to not only increase the number of staff who have their current vaccination status recorded, but also to increase the numbers of staff participating in the non-mandatory vaccination program.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Comments
There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. TGC has a risk-based approach and processes for preventing and managing infections in the workplace. Work health and safety and ICCNC work concurrently together to manage staff exposure. Initiatives to protect staff from Covid 19 were evidenced across the organisation and included, but not limited, to the provision of vaccines, fit testing for masks for staff working in high-risk clinical areas, and access to Rapid Antigen testing.

ACTION 3.16	
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection	
A tiered approach to outbreak and pandemic planning and management is in place.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.17	
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.	
Comments	
TGC undertakes no reprocessing of reusable equipment, instruments, and devices. All items are single use and stored in appropriate locations and containers across the health service.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.18	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement	
Comments	
TGC antimicrobial stewardship program is guided by evidence-based policy, and principally responds to the prescribing of oral antibiotics. 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).	
Rating	**Applicable HSF IDs**
Met	All

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

Standard 4 - Medication Safety

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

ACTION 4.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Comments
Healthscope and The Geelong Clinic's (TGC) policy and clinical practice guidelines / procedures apply a risk-based approach to effectively minimise incidents and harm. These documents are evidence-informed and accessible to staff at the point of care. Throughout the assessment, staff were able to demonstrate and describe the process by which they could access information to support their medication practice. The provision of medications and clinical pharmacy support is outsourced to Community Care. Staff are provided with medication management training that is aligned to their licensure, scope of practice, and roles and responsibilities. Such training commences at induction and continues across the employment continuum. Assessors noted the frequency and diverse training and learning opportunities available. The appropriateness and effectiveness of the training has yet to be formally evaluated. A suggestion has been made to incorporate a formal medication safety training evaluation and training needs analysis into the medication management audit schedule. At the time of the assessment, a number of medication risks across the medication pathway are reflected in the Healthscope risk register for the TGC site and reflect the sites specific risks. These are actively managed by the respective committees and demonstrate regular reviews and acceptance of current controls. Medication management is overseen by TGC Medication Safety Committee (MSC) which reports through the governance structure of the organisation and to staff and management. The committee's Terms of Reference has recently been reviewed. A suggestion has been made to review the terms of reference to include within the membership a medical practitioner, and to be more definitive in terms of monitoring, escalating, and responding to variance in medication safety and prescribing.
Suggestion(s) for Improvement
To incorporate a formal medication safety training evaluation and training needs analysis into the medication management audit schedule. To review the Terms of Reference of the Medication Safety Committee, to include: a) a Medical practitioner within the membership. b) the assignment of an executive sponsor for medication safety. c) specific reference to the review and management of medication safety / surveillance audits and performance metrics within the listed objectives. d) the documentation of a formal process and escalation pathway for ongoing variance in medication safety and prescribing performance metrics.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Comments	
The system supporting medication management is monitored through a range of performance measures which include audit, incident analysis, clinical reviews, pharmacy interventions, and consumer / carer feedback. The reporting of medication safety-related incidents is appropriate. Reports are provided through the clinical governance structure, and strategies are identified and actioned to improve performance when issues are identified. Assessors noted the Medication Safety Self-Assessment (MSSA) and the National Inpatient Medication chart audit (NIMC) compliance rate across a number of criteria were consistently below performance targets. Action plans designed to improve compliance have been incapable of generating the desired outcome on a consistent basis. Improvements to the system were noted, and these included initiatives to improve medication storage and safety, the provision of enhanced consumer information, and strategies to reduce medication administration errors.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
TGC aims to involve patients in their care by providing appropriate information about medications and fostering shared decision-making within the constraints of the person's legal status or capacity. Patients interviewed indicated that medications were discussed with them across their care continuum, that they felt involved in their treatment, and were able to understand the information provided. The inclusion of a medication safety session within the inpatient group programs is well received by patients. Carer and consumer feedback indicates a good response to questions that relate to engagement in treatment decisions across all care settings. The Consumer Consultant National Standards interview questions include a question that relates to medication safety education.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing, and administering medicines for relevant clinicians	
Comments	
Scope of practice with respect to medication management is assigned professionally through APHRA licensure and defined in policy and, where appropriate, in position descriptions and formulary restrictions for clinicians.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
A best practice medication history (BPMH) is undertaken as soon as practicable on admission and documented in the clinical record which is available throughout the patient's episode of care. At the time of the assessment, compliance with completing the BPMH for inpatient units is at 100%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.06	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	
The Geelong Clinic's Reconciliation of Medication Management flow chart describes the process by which the medication history and reconciliation process is undertaken. Interviews with clinicians together with a review of documentation and observations made by the Assessors confirmed that current medications are reviewed for accuracy and congruence with the BPMH on presentation and at transition points. Current performance data indicates that 97% of patient's current medications are documented and reconciled at the point of admission.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 4.08	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Comments	
The process for identifying and documenting medication allergies and adverse drug reactions experienced by a patient during an episode of care is well-defined and monitored. Medication allergies and adverse drug reactions are documented in the paper-based medication charts. Records reviewed by members of the Assessment Team indicated these were recorded. Compliance with documenting medication-related alerts is at 90%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.09	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
TGC has established processes for reporting adverse drug reactions to the TGA where required. This is primarily attended to by the pharmacists and to date there have been no notifications made by TGC.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Patients and carers are provided with sufficient information about treatment options to make informed choices about their medicines, and to achieve adherence with agreed treatment plans. Information is provided by a multidisciplinary team at various points across a patient's journey. Patients interviewed indicated that they were able to understand the information provided to them about their medications. TGC could give consideration to subscribing to Choice and Medication Resources - a repository of specific information about mental health medicines and conditions in a variety of formats and languages for staff, carers, and patients - as an adjunct to existing information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviewed confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. The provision of a current medication list is part of the formal discharge planning process for patients in both the community and inpatient settings and is provided to patients and their GP on discharge. Performance is audited and compliance is variable for inpatients. The provision of medication lists on discharge remains an active risk within TGC. A number of strategies have recently been introduced to improve compliance with variable success. At the time of the assessment, a focused quality improvement initiative was in progress, seeking to offset the complexities associated with the provision of the medication list on discharge within the context of limited onsite pharmacy support.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to a range of up-to-date and evidence-based medicine-related information and decision support tools that assist clinicians with their responsibilities to provide safe and effective medication management. These include, but are not limited, to access to online resources, coupled with regular medication safety information sessions, and targeted communiques. Clinicians reported being able to access this information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted, or expired medicines	
Comments	
TGC monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage - including cold chain management, distribution, and disposal of medications. Incidents are reported through the incident management system to the Medication Committee and through the safety governance framework. At the time of the assessment, assessors noted the number of completed unit-based improvement initiatives that relate to the storage of medicines. Suggestions made during the assessment included the separation of patients own medications from the current stock of dispensed items and the inclusion of the patients three identifiers on medication containers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense, and administer high-risk medicines safely	
Comments	
Interviews with staff and a review of documents supported the Assessors'' observation that high-risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing, and administration of those medications. Incidents related to high-risk medications are recorded in the incident management system. Lessons learnt from incident data analytics are communicated broadly to staff through the use of awareness posters and other quality and safety communication forums. The High risk medications and controlled Drugs Audit indicate high rates of compliance, at 91%, with established practice.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Comments	
Safety and quality systems have been implemented to support clinicians to deliver comprehensive care and minimise harm. A review of clinical documentation confirms that processes are in place for managing risks associated with comprehensive care and harm minimisation. At the time of the assessment, there were a number of risks pertaining to Comprehensive care and patient harm on the Healthscope risk register that related to the TGC site. All of these were assessed as having good controls in place with a residual risk rating of moderate which required ongoing monitoring. Observational audit and discussions with clinical staff over the assessment period demonstrated that staff understand and practice within established guidelines. The TGC Quality and Safety Committee (Q&SC) has the overall governance responsibility for the provision of Comprehensive Care. The Healthscope Comprehensive Care, Risk screening, and associated policies describe the processes to deliver comprehensive care and minimise harm. TGC policies, such as the Recovery-based care planning and evaluation policy, provide guidance as to how these apply within the service context of TGC. Training is provided to the clinical workforce at point of entry into the health service and throughout the period of employment. Such training is provided through a range of formal (Healthscope) and site / service-specific learning opportunities. Throughout the assessment it was difficult to identify the training program that applied to all members of the clinical workforce that related to the elements prescribed in the Comprehensive Care Standard.	
Suggestion(s) for Improvement	
To map the existing training provided to the clinical workforce that pertains to the elements within the Comprehensive Care Standard and address areas where training is not provided for the clinical workforce.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Comments	
Comprehensive care is defined and monitored by means of a comprehensive range of Corporate and site-based quality improvement activities established to improve care and minimise patient harm, which include auditing schedules, systems reviews, and performance indicators measuring compliance and clinical outcomes. Incident analysis, clinical review, and patient feedback are also utilised to monitor and measure the effectiveness of the system. Feedback on performance is provided through a series of scheduled narrative and dashboard reports to Healthscope and TGC safety and quality committees, senior leadership team, and clinical staff. Assessors noted the variability in performance across a number of audits and whilst actions are identified to reduce the risks associated with such practice(s) there has only been slight improvement overtime. Suggestions for improvement have been made in action 1.08 that seeks to address matters pertaining to consistently below target performance measures. Improvements to the system include the provision of gym equipment, the development falls resource folders for clinical units, the introduction of items of risk checklists in the Eating disorder kitchenette, consistency in completing patient care boards, and identifying positive meal support strategies for patients in the eating disorders programs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
A person-centred recovery orientated approach to care is adopted. Patients and their families, where appropriate, are actively engaged in their care and the consent process. Processes to encourage and support shared decision-making are evidenced across the care continuum, and outcomes of these conversations are visibly displayed at point of care on patient care boards and documented in individual patient's recovery booklets and various clinical records of patients. The patient /client YES experience surveys (Quarter 2 2023) rate their overall experience at 82.5 % which is above the corporate target of 82%. The Net promoter score for the last reportable period is at 43.9% which is below the target of 55%.Participation rates are at 24.21% which is marginally below the target of 25%. Actions listed in the TGC quality register (eQuaMS) seek to address the variances with varying success.

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	
Discussions with patients confirmed their active participation in their own care and inclusion in decision making. Staff were able to describe to the Assessors how they actively achieve this through recovery-focused, trauma-informed, and person-centred care approaches. Files reviewed incorporated patient goals and, where appropriate, their families and carers'' which demonstrated care partnership principles.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.04	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Comments	
Clinicians are supported by policies and procedures to undertake clinical risk screening and assessment, which are used to establish effective comprehensive plans for patients' care and treatment. Documents reviewed and discussions with staff confirmed systems are in place which supports the development and implementation of comprehensive care. Care plan formats are used and incorporate patient involvement. TGC operates within their licensure to provide care that best meets the patient's needs and has established protocols and processes for referral where needed. Assessors were unable to validate the appropriateness, responsiveness, and effectiveness of the referral process as no documented evidence of any reviews of the system were provided. Anecdotal evidence provided by staff indicated the responsiveness to referrals is appropriate. The clinician with overall accountability for a patient's care is defined as the admitting medical practitioner. Care is provided to patients in the most appropriate care setting.	
Suggestion(s) for Improvement	
To undertake a formal review of the internal and external referral process and make improvements to the system where required.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians and patients were able to describe how they work collaboratively to plan and deliver comprehensive care. This was further supported by the Assessor team who observed a number of bedside huddles, procedural safety time out, and clinician rounding over the course of the assessment. The outcomes of these multidisciplinary conversations were documented in the clinical record where appropriate.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm from referral to service and throughout the episode of care. Clinicians were able to describe the risk assessment process and evidence was sighted in clinical documentation. Patients described their involvement in screening and assessment processes and articulated their understanding of the process in relation to their care plan. Regular audits are undertaken to ensure timely and comprehensive risk screening and patient assessment is completed. Variances in performance are subject to review and improvement actions documented in eQuaMS. TGC is currently compliant with the requirements of the November 2022 Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
TGC demonstrates processes are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. Patients are routinely asked during the pre-admission assessment, and this is documented. This is audited and compliance is 100%. Staffs are trained in the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
The pre-admission assessment process includes the identification and documentation of patients with an advance care plan. Information and resources are available to support and assist patients to document advanced care plans.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental, and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive assessment is conducted at pre-admission, on admission, and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks, and the identification of social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the TGC governance structure. A limited review of clinical documentation by the Assessment team reinforced this. Whilst conducting a risk screening and assessment process review, Assessors noted the multiple points at which risk screening occurred and the number of risk screening and secondary assessment tools used by differing members of the clinical workforce. Duplicity within the system was evident and patients interviewed indicated that they were often asked the same question multiple times during the course of their admission. Performance compliance audits indicate variability in achieving established organisational target rates. A suggestion has been made to map the existing tools within the system and their utilisation to remove duplicity and improve compliance. TGC is currently compliant with the requirements of the Advisory AS18/14	
Suggestion(s) for Improvement	
To develop a Matrix of the current risk screening and assessment tools currently used across TGC (both electronic and paper based), the context in which they are utilised, the timing of the initial screening, and the clinician(s) responsible in order to remove duplicity and improve compliance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Clinicians articulated a continuous and comprehensive risk screening and assessment culture at TGC. Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. The most recent comprehensive care audit indicated an overall compliance rate of 85% for both care planning and risk screening practices.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk. In addition to targeted screening of mental health specific risks, the Healthscope Risk screening - Mental health Facility clinical record HMR 6.131, is utilised to screen for additional risks relating to a patient's physical condition. Whilst the screening of risks utilises validated tools, the actions that respond to the level of the risk are unclear, not always available at TGC and / or require secondary assessments to be undertaken by specialist staff. Risks and their mitigating action plan identified during this process are flagged with a tick box response that actions are to be incorporated in the Comprehensive care plan. The Record is collocated with the Mental Health Comprehensive Care plan at the point of care and reviewed every seven days.	
Suggestion(s) for Improvement	
To review the Healthscope Mental Health Risk screening clinical record to ensure that actions that respond to the level of risks identified can be implemented in TGC and clearly documented in the comprehensive care plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Comments	
TGC provides a person-centred recovery-focused model of mental health care. Clinicians and patients described a partnership approach when determining patient-centred goals and include the involvement of families or support people in decision-making. A review of clinical documentation by the Assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. Members of the assessment team witnessed interactions between staff and patients that demonstrated this partnership in care and decision making. The requirements of Advisory AS18/15 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	
During clinical visits, patients articulated that they felt empowered and engaged in their care, and decision-making at all points of care and transition. Goals of care are regularly discussed and monitored, and care plans modified in response to changes in goals, clinical status, needs, or risk profile.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
Pre-admission assessment and admission processes include the identification of people who may be at the end of life. As a mental health hospital, a robust pre-assessment process is in place to ensure patients receive the most appropriate care in the most appropriate setting hence, persons in the end-of-life phase is listed as exclusion in the TGC Admissions of a patient – Mental health facility policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16		
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice		
Comments		
Assessors rated this criterion as Not Applicable.		
NA	All	**NA Comment:** End-of-life care is not provided, and the arrangements as described are well-established and articulated by staff interviewed. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
Pre-admission assessment and admission processes include the identification of patients with an advanced care plan. Patients are asked to provide a copy of the plan prior to admission, and the plan is documented in the patient's health care record.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18		
The health service organisation provides access to supervision and support for the workforce providing end-of-life care		
Comments		
The Assessors rated this criterion as Not Applicable.		
NA	All	**NA Comment:** End-of-life care is not provided, and the arrangements as described are well-established and articulated by staff interviewed. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

ACTION 5.19		
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care		
Comments		
The assessors rated this criterion as Not Applicable.		
NA	All	**NA Comment:** End-of-life care is not provided, and the arrangements as described are well-established and articulated by staff interviewed. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

ACTION 5.20		
Clinicians support patients, carers, and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care		
Comments		
The assessors rated this criterion as Not applicable.		
NA	All	**NA Comment:** End-of-life care is not provided, and the arrangements as described are well-established and articulated by staff interviewed. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
Evidence-based guidelines have been utilised to support staff in the prevention and care of persons at risk, or with a pressure injury. The framework incorporates policy directives, procedures, and screening (Waterlow) and assessment tools. The system is well-structured, comprehensive, and accessible to staff. Wound management is under the remit of the General Practitioner or members of the nursing team with wound experience. Access to a regional wound nurse consultancy service, or similar, is currently being explored. The incidence of hospital acquired pressure injuries remains at zero.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Comprehensive skin assessments are attended to on admission and key care points across the patient journey, where appropriate. Staff provide trauma informed care and were able to articulate how they adopt this approach in determining the risk assessment requirements for skin inspections. These are documented in the clinical record and form part of the clinical handover.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Patient and carers are provided information about preventing and managing pressure injuries throughout their episode of care. Conversations with patients throughout the course of the assessment period indicated that they were engaged in their treatment and provided information about their care and the importance for them to be mobile. A very limited range of products, equipment, and devices are available at each site, however, are accessible through existing pharmacy or procurement processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
Evidence-based guidelines underpin TGC policy and procedures, which are utilised to support staff in the prevention and care of persons at risk of a fall. Screening and assessment tools are commenced on admission and utilised across the care continuum. Falls risk resource folders have recently been created for each clinical unit as a ready reckoner for all things related to falls prevention and management. Staff are orientated to falls management practices at induction and throughout their employment period. The recent Comprehensive Care audit indicates that compliance with established processes is at 87%. The inpatient falls rate is 0.12% which is below benchmark Healthscope's tolerance rate of 0.24%. There have been no SAC1-rated incidents.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices, and tools are available to promote safe mobility and manage the risks of falls	
Comments	
A limited range of equipment and devices are located at each site and staff are trained in their use, however, are accessible through existing pharmacy or procurement processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers, and families with information about reducing falls risks and falls prevention strategies	
Comments	
Patient and carers are provided information about falls prevention throughout their episode of care by a range of communication and engagement methodologies. Bedside care conversations are utilised in accordance with the patient's risk profile. A range of printed falls management materials are available. Patient conversations over the assessment period indicate that they were engaged in their treatment and provided information about their care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
Nutrition and hydration management procedures provide operational support for staff, optimising nutrition, and hydration, to promote wellbeing, recovery, and the prevention of malnutrition and metabolic disorders. Food and nutrition services are provided by appropriately trained staff with clear roles and responsibilities assigned according to role delegations and scope of practice. The TGC kitchen is a food production kitchen and has current HACCP accreditation. Skills development and awareness training sessions are attended on a need's basis. Malnutrition risk screening and assessments occur on admission to the clinical unit and at agreed intervals across the patient journey and recorded in the clinical record. Validated tools are used and a positive screen generates a number of interventions which may or may not include a referral to the dietetic services. Responsiveness to referrals is timely. Secondary assessments and nutrition plans are formulated where appropriate, monitored, and recorded. Compliance rates for malnutrition risk screening on admission is at 72%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Comments	
The system supporting nutrition and hydration is monitored through a range of performance measures, incident analysis, and patient feedback. No nutrition related incidents have been reported into the Riskman system to date. Consumer feedback is actively involved in the evaluation of the service and food quality. Conversations by the assessment team with patients suggested a reasonable level of satisfaction with the meals provided.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
Policies, congruent with the Clinical Care standard, are in place which outlines best-practice strategies for the early recognition, prevention, treatment and management of cognitive impairment, and staff were able to articulate these during clinical rounds. Cognitive screening is undertaken using validated tools on admission and as required throughout a patient's admission, where clinically indicated. Where delirium or deterioration in cognition is identified, patients are reviewed by their treating doctor and / or transferred to a more appropriate care facility. Care plans are regularly reviewed in partnership with patients and their carers. This includes the use and monitoring of medications to ensure compliance with best-practice standards. Screening rates are audited and reported through the organisation's governance structure. Substitute decision makers are identified on admission and documented electronically and / or into the paper-based file in the clinical units. Staffs are orientated to delirium and cognition practice across their employment through a range of learning opportunities. TGC is compliant with the requirements of Advisory 18/12 (1.27b) and ACSQHC Fact Sheet 11 (5.29a).

Rating	Applicable HSF IDs
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
Delirium and cognition screening commences on admission to the clinical unit. The CIRAT screening tool for Delirium and Cognitive impairment is used as the primary screen. If a positive screen is identified, a 4AT or other secondary assessments are to be completed. The system supporting delirium and cognition is monitored via incident analysis, clinical reviews, and patient feedback. Compliance with screening for Cognitive impairment risk is at 97%

Rating	Applicable HSF IDs
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers, and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Strategies and risk screening tools are in place to identify patients at risk of self-harm and / or suicide. On identification of patients who may be at risk there are documented intervention strategies that staff were able to articulate, and these were confirmed on review of medical records.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated, and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Where patients have self-harmed or reported suicidal thoughts, clinicians have access to timely follow-up and referral service through the Community mental health service. Staff were able to describe how they would access and use these services. Follow up arrangements for the transition of ongoing care are developed and communicated to the respective community service agencies and general practitioners, where appropriate.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The identification of potential aggressive and / or challenging behaviours are identified during pre-admission screening, on admission, or through the episode of care and are flagged in the patient administration and clinician record. The geographical placement of persons at risk in the clinical unit are considered with consideration of both clinical, patient experience, and safety needs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers, and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
TGC has strategies and processes in place to identify patients at risk of becoming aggressive including the use of Alerts in the WebPas system and the application of de-escalation strategies. The processes to manage aggression aim to minimise harm to patients, staff, and visitors. Staff were able to describe how they work with patients and others to implement these strategies effectively. Incident of aggression are reported through the organisation's governance structure. Collaborative processes are used to minimise the risk of aggression and violence, and the incidents are managed safely when they occur. A Code Black emergency call is triggered for patient-related episodes of aggression and / or challenging behaviour. Events are recorded. A recommendation has been made in action 1.30 that responds to the management of occupational violence and aggression.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Policies and processes are in place to govern and manage the use of both chemical and physical restraint, and these include alternative strategies to minimise the use of restraint. TGC is a non-gazetted organisation and patients are admitted voluntarily. During clinical rounds, staff were able to describe the system in place to minimise and eliminate the use of restraint. TGC provides therapeutic in-patient and day programs focused on recovery and empowerment of patients. Staff are trained in therapeutic engagement and de-escalation techniques. When patients exhibit harmful behaviours outside of the scope of the organisation, this triggers the escalation pathway and transfer of care process to the most clinically appropriate setting. This involves the attendance of emergency services to the organisation. Incidents are documented in the patient record and in the incident management system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.36		
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body		
Comments		
Seclusion is not an endorsed practice at TGC.		
NA	All	**NA Comment:** The assessment team validates that no seclusion is utilised at The Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Healthscope and TGC have effective policies and procedures to enable clear and concise clinical communication between clinicians. Clinical file notes are legible, signed, dated, and designation of clinician entered. Clinical files are audited. If an incident occurs involving miscommunication between clinical staff, training would be implemented to improve communication skills.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
Audits are conducted on the clinical handover processes. Observation of the handover, witnessed by the Assessor team, demonstrated staff ability to speak clearly with patients, outline clinical care treatment plans, and listen to what the patient had to say about their care. Audit results on clinical handover documents and observational audits are tabled and discussed at the Quality committee. Where further training on handover documentation is needed, it is arranged.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers, and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
At handover times and other times of staff and patient interactions, it was observed by the Assessor team to be respectful, seeking the patient's view on treatment progress and sharing information to assist the progress of the patient. When an incident occurs that is rated as a high risk, the staff contact the patient's family or guardian to inform them of the incident and of what action have or will be implemented to address the incident.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
All patients at TGC wear an identification wrist band that has the patient identifiers on it. If the patient wishes to not have the wrist band on when on approved leave from the clinic, the band can be removed, but on return a new band is put on. Each patient is asked for three identifiers prior to receiving medication. This is then checked on the medication chart, which has a photograph of the patient attached to it. At the bedside handover, the patient is asked his / her name, date of birth, and the patient's wrist band is checked. At discharge, a comprehensive nurse discharge summary is written that contains clinical information, known risks, and treatment progress.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.05	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy, and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
There is a policy and procedure for staff to adhere to when asking for patient identification. Audit results indicate that compliance is very good. The three approved identifiers are always asked prior to medication being given, prior to Interventional procedures, ECT, TMS or Ketamine medication. ECT and TMS treatments were observed, and patient identification was asked and confirmed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.06	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
Procedures are in place for staff to correctly identify patients in their care. Time out procedures were observed and correctly documented. The patient was asked to identify him/herself and the staff then confirmed the patient's identity.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.07	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	
Clinical handover documentation contains the required minimum content, the relevant risks and needs of the patient, and staff are involved in handover processes. Clinicians who run the group programs throughout the day enter clinical notes on each patient who attended the group into the patient clinical record. This information is valuable at handover times in understanding how the patient is doing during the day.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.08	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers, and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Comments	
The bedside handover occurs at each nursing shift change. The nurse coming on who will look after the patient is introduced to the patient. The communication board in each patient's room is updated at handover. The patient's goals are discussed and refreshed, if needed, on the board, and estimated discharge date and the patient's plans are discussed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.09	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts, and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Comments	
TCG has policies and procedures to guide clinicians in the effective handover of critical information, including risks and alerts. Nurses can increase the observation level of a patient based on their judgement but the nurse cannot decrease the observation level; only the treating doctor can decrease the level. Patients and carers are involved in the communication of critical information as the need arises. If a patient is absent without leave, the next of kin is contacted to see if they know the whereabouts of the patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers, and families to directly communicate critical information and risks about care to clinicians	
Comments	
Information and posters are on the wards informing carers and family members to see a nurse if they have any concerns or critical information regarding the care and treatment of the patient. Patients interviewed by the Assessor team confirmed that the information is available, and the patient and family are supported in raising any concerns about treatment to the staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
The medical record for each patient is kept in the nurses' station and are readily available for any clinician to access. Records viewed by the Assessor team confirmed compliance with TGC policies on completeness, accuracy, and contemporaneous clinical notes. Audits on the clinical record are scheduled throughout the year. Areas for improvement in the clinical record are discussed and action planned at the Quality and Safety and Heads of Department committee(s).	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.02		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.03		
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.04		
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.05		
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.06		
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.07		
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.08		
The health service organisation participates in haemovigilance activities, in accordance with the national framework		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.09		
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute, and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 7.10		
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage		
Comments		
Approved as Not Applicable.		
NA	All	**NA Comment:** The Assessment Team verifies that no blood nor blood products are prescribed or administered at the Geelong Clinic. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
Healthscope and TGC have policies and procedures in place for staff to recognise and respond to patients who might be deteriorating. Staff spoken with were able to describe what they would do in a situation of acute deterioration in a patient. Staff have received BLS training, medical emergency response training, and prevention and management of aggression.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
Policies provide clear guidance for staff to recognise and respond to physical and / or mental state deterioration. Physical vital sign observations are recorded twice daily. Staff are aware of actions to be taken if vital signs are outside of accepted parameters. Mental health risk assessments are conducted regularly throughout the day to monitor possible mental state deterioration. A deterioration incident is entered into Riskman which then prompts a critical system review of the incident. The review and actions are tabled at the appropriate TGC committee. At Professorial rounds, the deterioration incident is examined, and learnings identified with staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Patients are actively encouraged to become more aware of their own signs of physical and / or mental state deterioration. Family members are also encouraged to be aware of their relative's well-being so they can inform staff if they have noticed any deterioration in their relative's wellbeing. Through group and individual therapy modalities, the patients learn to be more alert to their own changes in their wellbeing and are encouraged to seek out staff support as soon as possible. This enable patients to be actively involved in shared decision-making with staff. This process was confirmed in an interview with a patient who told about how she sought staff help when she was not feeling well, and a collaborative plan was put into action.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital signs are monitored twice daily and entered into the observation chart. Audits are done to check compliance with policy and procedure on monitoring vital signs. Patients whose mental state requires closer observation are in rooms close to the nursing station, and the frequency of their nursing observation level can be increased as needed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.05	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Comments	
TGC have established good processes to monitor, assess, and determine further actions to ensure the safety and wellbeing of the patient is achieved. Staff spoken with were aware of the advisories AS22/01 and As19/01. Staff could outline actions to be taken if a patient's mental state began to deteriorate or was at risk of developing delirium. Individual care and management plans in the clinical record would be developed with the treating psychiatrist and clinical team. Relatives are notified and kept informed about the possible causes of the deterioration and the treatment plans to address the deterioration. Moving the patient closer to the nurse's station, cancelling leave arrangements, medication adjustment, and increasing nursing observation levels could be in a response plan to mental deterioration. The requirements of AS19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.06	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Comments	
TGC has systems in place to monitor the management of vital sign parameters, mental state deterioration indicators, and concerns raised by family members, patients and staff through the clinical file audits, and the incident management system. Staff were able to describe to the Assessor the indicators and process for calling for emergency assistance. Staff interviewed indicated that if a patient's distress and behaviours could not be managed safely at TGC, processes would be enacted to ensure the patient is maintained in a safe environment by staff and arrangements made to transfer the patient to the nearby public mental health service. Relatives would be kept informed at all times. After this type of incident, debriefing and support of staff and any patients in the vicinity would occur. The requirements of AS19/01 (8.06 a,b,c,d,e) have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers, or families to directly escalate care	
Comments	
Patients, their family members, and carers are provided with written information and are encouraged to let staff know if they believe an increase in clinical supervision is needed for their relative. Patients are encouraged to let staff know if they are feeling unwell and need more clinical care or observation. The patient the Assessor spoke with confirmed that she or her relatives are encouraged to approach staff to seek an escalation of care. The patient said she has done this on occasion and staff responded appropriately.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
There are systems and protocols that staff have been trained in to escalate care and how to call for emergency assistance. Staff spoken with were able to describe the process to call for emergency assistance and staff noted that the timely response rate from other nurses was excellent. If further emergency assistance is needed, then the staff call 000 number for police or ambulance assistance. The staff spoken with could not recall the last time police and or ambulance had to be called. Any occasion where internal or external emergency call for assistance was made would be recorded in Riskman, and a critical incident review would be mandated.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
The processes at TGC clearly guide the staff in when and how to escalate care in response to patient deterioration. Staff were able to describe the process and the Assessor saw documentation that supported what staff indicated. Relevant TGC committees would evaluate the recognition and response processes through the mechanisms of the quality framework.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Training is provided to clinicians to enable then to respond competently and effectively to patients requiring assistance due to deterioration of their condition. The training compliance rate of staff in the systems to respond to an episode of acute deterioration meets training targets.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
TGC has rapid access to the "000" emergency response at times when advance life support is needed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
There are effective processes for the rapid transfer of a patient to the public mental health service in Geelong if a higher level of care is required for the patient's safety. Staff were able to describe the referral process and the documentation that would accompany the patient's transfer. The patient's family or carer would be notified of the transfer to the acute care service. The requirements of AS19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
TGC has effective processes in place for the rapid transfer of a patient requiring acute physical care in a general hospital. Documentation describing the medications and care plan of the patient would accompany the patient to the hospital. The same process would be initiated if the patient was experiencing delirium and required further investigation. All incidents of escalation of care are monitored through the Heads of Department committee.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

NIL