# NSQHS Standards Second Edition Version 2 Interim Accreditation Assessment

## *Final Report*

La Trobe Private Hospital

BUNDOORA, VIC

Organisation Code: 226621
Health Service Facility ID: 101079
ABN:69 108 807 370
Assessment Date: 15-16 February 2024

Accreditation Cycle: 1

**Disclaimer:** The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the ongoing safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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# 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, 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** | 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. 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.**<br>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. |

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

### Repeat Assessment

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

### Safety and Quality Advice Centre and Resources

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

# Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *NSQHS Standards Second Edition Version 2 Interim Accreditation 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.

This is the first time this organisation has been accredited.

# Assessment Team

| Assessor Role | Name | Declaration of independence from health service organisation signed |
|---|---|---|
| Assessor | Mary Hyland | Yes |
| Lead Assessor | Wendy Wood | Yes |

# Assessment Determination

ACHS has reviewed and verified the assessment report for La Trobe Private Hospital. The accreditation decision was made on 22/02/2024 and La Trobe Private Hospital was notified on 22/02/2024.

**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

La Trobe Private Hospital underwent a NSQHS Standards Second Edition Version 2 Interim Accreditation Assessment (NS2.1 Interim) from 15/2/2024 to 16/2/2024. The NS2.1 Interim required two assessors for a period of two day(s). La Trobe Private Hospital (LPH) is a private health service.

The PICMoRS assessment methodology was used to conduct this assessment. Approximately 82% of assessor time was spent in operational areas during the assessment.

A team of two assessors reviewed the newly refurbished Healthscope facility at Bundoora, Victoria over two days. A contemporary, calm, and visually pleasing clinical environment has been developed over three floors of a pre-existing building. Overnight patient care and services commenced the week prior to the assessment. Medical and surgical specialists are already working at North Park hospital nearby, which is managed and operated under the same governance structure as La Trobe Private Hospital, and have had their scope of practice extended to include the new facility.

All applicable and prescribed actions have been assessed as meeting the requirements for Interim Accreditation in accordance with AS18/02 and the Guide for Interim Accreditation. The previously submitted Not Applicable Action was verified as appropriate.

Healthscope governance processes are in place to support the startup of clinical services. The assessors met with the Hospital's General Manager and leadership team, who, in addition to the unit managers and staff, are responsible for the safe operation of the new hospital. Monitoring and evaluation processes are in place, with data collection and reporting already in progress. The site team members were enthusiastic and reported that they were fully competent and prepared for the future clinical workload.

There has been substantial planning and recruitment of a Consumer Consultant who felt valued and supported. LPH also has access to the Healthscope consumer groups, including the national cultural diversity group and support from the Northpark Consumer Consultants and program, while it consolidates its own plans.

HICMR infection prevention and management processes have been adopted and implemented. The risks to the patient population have been considered during the planning of the design of the facility, fittings, and furniture which has resulted in a pleasant, clean environment that should be easily maintained. Monitoring and reporting systems are in place, with a HICMR Consultant on board two days per week. The relationship between the patient, family or carer and the clinical team is built on shared decision making, with the clinical team tailoring communication to suit the needs of the patient and the situation that the patient is in. Ongoing feedback from patients will be sought to monitor this.

The Medication Safety system has been designed in accordance with legislative requirements and Healthscope policies and procedures. The best possible medication history is taken at admission by nurses. The pharmacists manage the safe, secure storage of medicines, including high risk medicines, with adverse drug reactions to be reported to the TGA, in accordance with policy.

The Care Boards and care planning support partnering with consumers, which was described as being fundamental to the multidisciplinary teams, and achieving the patient's goals of care. There is minimal reporting at this stage, however there was preparation for the first end of month cycle of audits and reporting. There was also a comprehensive approach to the ACSQSH Clinical Care Standards with gap analyses completed for those not implemented and actions plans.

The communication of critical clinical information was appropriate, and staff were observed to be comfortable in the use of ISBAR, and with bedside handovers and transition of care points. Implementation of Healthscope policies, for example, alerts and identifiers, was evident; however, compliance will be monitored through the 2024 audit schedule.

Processes and arrangements are in place with Melbourne Pathology service which is contracted to manage the availability of blood and blood products, eliminate wastage, and respond to shortages. As nursing staff are recruited, competency training is provided during onboarding education.

The systems in place for the recognition, response, and management of deterioration have been tested, staff have been trained, and the equipment is accessible and contemporary. The implementation of the REACH system on the stand-alone site and its 24-hour access to a staff member provides a reliable method of contact for consumers, families, and carers.

# Summary of Results

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

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

# Sites for Assessment

## La Trobe Private Hospital

| Site | HSFID | Address | Visited | Mode |
|---|---|---|---|---|
| La Trobe Private Hospital | 101079 | Cnr Greenhills Rd & Plenty Road BUNDOORA VIC 3083 Australia | Yes | Onsite |

# Shared and Contracted Services

A sample of Contracts have been verified.
The following contracted services are used by La Trobe Private Hospital.

| Provider | Description of Services | Verified During Assessment |
|---|---|---|
| Lumus Imaging | Radiology and Imaging | Yes |
| Melbourne Pathology | Pathology | Yes |
| Chemtronics (Corporate Contract) | Biomedical Maintenance | Yes |
| HICMR | Infection control Consultant | Yes |
| BGIS | Maintenance | Yes |
| HPS | Pharmacy | Yes |
| Wormald | Fire panel service | Yes |
| Spotless (corporate contract) | Linen | Yes |
| Coregas | Medical Gas Supply | Yes |
| Busch | Medical Suction | Yes |
| Testel | Testing and Tagging | Yes |

La Trobe Private Hospital has reviewed these agreements for the listed services in the 3 years preceding this assessment.

# Standard 1 - Clinical Governance

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

| **ACTION 1.01** | |
|---|---|
| The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance | |
| **Comments** | |
| A review of the Senior Leadership Team (SLT) meeting documentation demonstrated that all items relevant to safety and quality of care were documented. Interviews with the General Manager (GM) demonstrated that a culture of safety and quality improvement had been pursued as per the Consultation, Representation, and Participation policy, and the Duty of Candor policy for Victorian sites. This was reinforced by the leadership team which sets the organisation's operational goals and is responsible for ensuring it is clearly communicated through the governance structure, including a calendar of committee meetings. The 'One Healthscope' Strategy was quoted as providing the priorities and strategic directions for all hospitals in the group. The Clinical Governance Framework describes the clinical governance structures and relationships for safety and quality of care. Together with the Facility Rules, governance-related roles and responsibilities across the hospital are well defined. Committees have been established to monitor the effectiveness of the clinical quality system through feedback, audit, data analysis, and incident reporting. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.02 | |
|---|---|
| The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people | |
| **Comments** | |
| Healthscope has a formal Reconciliation Action Plan (RAP) which is used at all hospitals. Refreshed in 2024, the plan includes provision of services to address unmet needs, encourage participation through employment, and respecting the culture through acknowledgement statements and participation in national events. | |
| **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** | |
| Staff in key clinical governance and leadership roles were able to describe the implementation of the clinical governance framework. Managers were able to demonstrate to the assessment team how its effectiveness will be monitored and reported, including daily safety huddles, audits, 'MARS' reporting, RiskMan entries, committees and working groups, and patient and staff experience feedback. | |
| **Suggestion(s) for Improvement** | |
| Consider the role of working groups in the post-commissioning phase. If these are to be ongoing and responsible for the implementation of improvements and performance monitoring, responsibilities of each group / committee should be defined in Terms of Reference, with formal records of meetings. | |
| **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** | |
| The RAP includes the reporting required to be implemented at La Trobe PH. This includes engagement with local Aboriginal & Torres Strait Islander communities. The RAP includes actions to ensure there is culturally appropriate care, and that clinical care is provided in accordance with demand. | |
| **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** | |
| Interviews with senior managers and the GM confirmed that issues of access to private health services in the region contributed to the decision to develop the hospital and expand on the services provided at NorthPark Hospital. New business proposal and procurement templates include safety and quality of care as essential elements in decision-making. Escalation processes include risk analyses, incidents, complaints, consumer, and staff feedback in decision-making processes. Dedicated positions are appointed at group corporate level to support procurement. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.06 | |
|---|---|
| Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients | |
| **Comments** | |
| A review of governance and reporting structures, reinforced by assessor observations and interviews with staff, verified that the Clinical Governance Framework and the Facility Rules are used to describe roles for staff. Staff confirmed that they understood their clinical safety and quality responsibilities and were able to articulate how the hospital will contribute to the organisational-wide monitoring, reporting, benchmarking, and evaluation of performance. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.07 | |
|---|---|
| The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements | |
| **Comments** | |
| Documents reviewed, plus interviews with the senior managers, demonstrated that policy documents, procedures, and protocols are managed to ensure that they are current, comprehensive, effective, appropriately referenced, and compliant with legislation and regulations, along with Victorian Safer Care requirements. A corporate policy specifies their governance, and the processes are supported by a National Document Control officer. Compliance is to be monitored through incident reporting and analysis of trends which will influence the revision of site-specific policies, procedures, and protocols, where indicated. A risk management approach was evident in defining the adaptation of organisational documents specific for use at La Trobe Private Hospital. | |
| **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** | |
| Healthscope has a defined quality management system, 'Qualtrics', that records and reports performance and outcome data. Staff confirmed that they had received information on quality and safety performance from other sites in the group. Outcome data and information from La Trobe will be used to drive improvements through the governance structure, and all information will be made available to staff through staff meetings to consumer representatives, the community, GPs, and other stakeholders who will be engaged in performance evaluation. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.09 | |
|---|---|
| The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations | |
| **Comments** | |
| Senior staff confirmed during interviews how the organisation manages the safety and quality system in accordance with the Quality Management Policy. Reports are to be provided to the Healthscope leadership and Board quarterly. Newsletters and website reporting are planned, and staff engagement is encouraged through committee representation and departmental quality boards. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.10 |
|---|
| The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters |
| **Comments** |
| Management and staff explained how risks are to be identified and managed, and how this is influenced by the Duty of Candor, feedback and input from staff, patients, and carers. The GM articulated how the Quality Risk Committee uses a risk matrix to define and operationalise the risk management system in accordance with the Clinical Risk Management policy. The Medical Advisory Committee and specialty craft groups will also be involved soon. The risk management system includes business continuity plans to support service delivery in the case of an emergency or disaster. Risk management reports are included in all committee Terms of Reference. |

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

| ACTION 1.11 |
|---|
| The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems |
| **Comments** |
| Documents reviewed included the Serious Adverse Event Review and Root Cause Analysis policy, plus interviews with staff, confirmed that all staff have been orientated to the RiskMan reporting system and that they are encouraged to report any incidents or 'near misses'. The Quality Risk Committee will provide analysis and feedback to staff and key committees on incident reporting trends and make updates to the risk register. Information on the outcomes of incident investigations is to be reviewed at the individual incident and aggregate levels to ensure the system is functioning as intended and to inform improvements, where indicated. |

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

| ACTION 1.12 | |
|---|---|
| The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes | |
| **Comments** | |
| The organisation has established an open disclosure program which is consistent with the Australian Open Disclosure Framework. How, why, and when open disclosure occurs will be monitored. No open disclosure occasions have occurred to date. Staff were able to articulate their role in open disclosure and felt supported in initiating and participating in open disclosure. | |
| **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** | |
| A variety of mechanisms are in place to seek and respond to feedback from patients, carers, families, and staff about the quality of care provided by the organisation. Feedback from satisfied consumers has already been received. Feedback will be analysed, trended, and reported. A consumer survey is planned, and results will be used to inform quality improvement strategies. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.14 |
|---|
| The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system |
| **Comments** |
| The organisation's complaints management policy and procedures describe the processes in logging and responding to complaints. The policy describes how staff and consumers are to be appropriately involved in the review of complaints, and that they are to be resolved in a timely way. Complaints will be used to inform the risk register. No complaints have been received since commencement. |

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

| ACTION 1.15 |
|---|
| The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care |
| **Comments** |
| Documents reviewed, plus interviews with senior staff and management, confirmed that the group analysed the demographics of its local population and the broader community to identify those patients who are at a higher risk of harm, including accessibility and cultural and linguistic diversity. This information was used to support decisions on service delivery and the design of the footprint to identify how to best address needs. Processes are guided by the Gender Identity, Sensitivity and Cultural Safety policy. |

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

| ACTION 1.16 | |
|---|---|
| The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used | |
| **Comments** | |
| The healthcare record is in hard copy for the duration of each episode of care and is readily available to clinicians at the point of care. An examination of a small set of records demonstrated that it is organised in such a way as to support accurate, comprehensive, and timely documentation. Clinicians were able to describe how they use the healthcare record to document all aspects of care planning and delivery. On discharge, healthcare records are maintained securely in a locked department and comply with privacy legislation. Regular clinical documentation audits are scheduled to be undertaken, and reports will be provided to clinicians, departments, and key committees. Ward clerks are required to check each record for key components on discharge. | |
| **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** | |
| Each printed medical record page is barcoded and Healthscope is working toward electronic health records. Patient identifier numbers are unique to the hospital. Standardised terminology is to be used. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.18 |
|---|
| The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system |
| **Comments** |
| The corporate office has undertaken a gap analysis, and the resulting action plan demonstrates that most activities are 'ongoing.' The organisation is compliant with the requirements of AS18/11 v5 in December 2023. |
| **Suggestion(s) for Improvement** |
| It is suggested that to facilitate ongoing monitoring and evaluation requirements by December 2024 of Actions 1.17 & 1.18, more details on the actions should be included in the plan, and timelines and persons responsible are identified. |

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

| ACTION 1.19 |
|---|
| The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation |
| **Comments** |
| The assessment team reviewed documentation that detailed the orientation provided to all new staff. The onboarding processes included identifying quality and safety roles and responsibilities, and position descriptions further supported this. Commencement training records are maintained and were made available to the assessors. |

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

| ACTION 1.20 | |
|---|---|
| The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training | |
| **Comments** | |
| The Mandatory Training policy describes the processes to ensure that clinicians undertake training appropriate to their roles. Training records via 'Dash' were made available to assessors. The compliance rate for mandated safety training was noted to be 70.3%, with a target of 92% over the coming weeks. The Training Requirements for Credentialed Practitioners policy specifies education for clinicians appropriate to their roles. | |
| **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** | |
| Meeting the health care and cultural needs of Aboriginal and Torres Strait Islander people is described in the Appropriateness of Care policy which aims to inform staff about the Cistone, values, and beliefs of Aboriginal and Torres Strait Islander Peoples in relation to their health. In addition, National Cultural Diversity & Inclusion Committee publicises and encourages participation in national and local activities. 50% of the staff have completed 'shared the pride' module of e-learning, with administrative staff at 100%. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.22 | |
|---|---|
| The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system | |
| **Comments** | |
| Staff performance reviews are to be conducted annually for all staff, with 3- and 6-month reviews scheduled for all the new staff. The process includes identification of staff training needs. Staff could articulate the performance management system and their role in the process. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.23 | |
|---|---|
| The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered | |
| **Comments** | |
| Defining the scope of clinical practice is managed by the GM, and supported by senior administrative staff, and is guided by Healthscope policy and procedures. Clinicians' scope of practice is consistent with the role delineation of NorthPark and La Trobe hospitals. Currently the scope of La Trobe Private Hospital is restricted to Paediatrics >12 years. There is a corporate policy that guides the process to consider new interventional procedures. | |
| **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** | |
| Several new medical staff are undergoing the appointment process; it was reported that most were currently credentialed at NorthPark and had their scope increased to include La Trobe PH. Theatre and booking staff have full access to enable them to check scope of practice at any time. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.25 | |
|---|---|
| The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff | |
| **Comments** | |
| Staff interviewed by the assessors were able to articulate their roles and responsibilities for quality and safety. These are defined in staff position descriptions, and in the By-Laws for medical specialists. Orientation and onboarding include information for agency and locum staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.26 | |
|---|---|
| The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate | |
| **Comments** | |
| Clinicians are provided with supervision according to their designated roles and responsibilities via the leadership structure, and this is supported by position descriptions and the Clinical Governance structure which includes the Medical Advisory Committee. Specialists are on call after-hours, and staff can contact them as required. There are no appointed Junior Medical Staff at this time. The after-hours hospital co-ordinator is designated as the first contact person, and senior managers are rostered on-call. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.27 | |
|---|---|
| The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care | |
| **Comments** | |
| The organisation provides clinicians with access to a range of tools, best practice guidelines, care pathways, and the clinical care standards to support their clinical practice. Some Health Record forms also include guidance; examples cited were diabetes, delirium, deterioration. Mandated Clinical Care Standards relevant to the service, AMS, colonoscopy, and Delirium Management have been implemented. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.28 |
|---|
| The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system |
| **Comments** |
| Clinical variation is to be monitored by analysing comparative clinical outcomes data (both internal and external) and results are to be used to inform individual and aggregate performance, support visiting clinicians in actively participating in clinical reviews and to inform changes needed to minimise unwarranted clinical variation via the MAC, and Mortality and Morbidity committees. A plan is in place to implement craft-specific meetings once occupancy and activity levels rise. The hospital plans to contribute to the ACHS clinical indicators program. |

| 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** |
| Interviews with staff and observations by the assessment team demonstrate that the fit-out of the new hospital has been carefully designed so that the preventative and reparative maintenance of buildings, plant, equipment, utilities, devices, and other infrastructure can be easily undertaken by staff or contractors to ensure that they continue to be fit for purpose. |

| 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 look and feel of the design of the fit-out and furnishings promotes a calm and quiet environment. There are several places that provide additional privacy. The organisation has identified that although there is a low risk of unpredictable behaviours, it has processes to ensure emerging risk issues can be appropriately identified. Strategies include alert and staff assist buttons in all clinical care spaces. Referral processes to NorthPark Hospital are established. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.31 | |
|---|---|
| The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose | |
| **Comments** | |
| Internal and external directional signage is designed to be clear and fit for purpose. Once on the hospital grounds, the assessment team were able to successfully navigate the unfamiliar environment. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 1.32 | |
|---|---|
| The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so | |
| **Comments** | |
| Visiting hours are promoted to facilitate patient rest periods, however, they were described as being flexible, in accordance with needs. | |
| **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** | |
| The welcoming feel of the environment is enhanced by art works that have been commissioned or purchased from Aboriginal communities across Australia. Acknowledgement of County is practiced, and Aboriginal and Torres Strait Islander flags were on view in front of house reception. Windows to the garden views were seen in all patient care areas. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 2 - Partnering with Consumers

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

| **ACTION 2.01** | |
|---|---|
| Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers | |
| **Comments** | |
| The principles of safety and quality were evident in the Healthscope policy documents that are referenced by LPH, including the 'Partnering with Consumers' policy and the Northpark and LPH Consumer and Diversity Engagement Plan 2020-2024.<br><br>The orientation program completed by staff prior to the recent opening included relevant policy documents for Standard 2. The annual training calendar for 2024 includes one Standard per month, and as with the other standards the planned intensive education options are reflected in the calendar for April 2024. | |
| **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** | |
| Through a review of documentation and interviews with staff and consumers, the assessors confirmed that LPH focuses on partnerships with consumers at all levels. There was a structure of committees and subcommittees supporting monitoring and reporting, however these forums are yet to meet. The Consumer Consultant interviewed was aware of the Healthscope-required Foundations training program and had completed two of the four modules. There was also planned orientation to the scheduled Consumer Consultation Committee and the Quality and Risk Committee. The intent to have greater representation on committees was evident, however access to consumer consultants was recent. LPH had commenced working toward consumer consultants at Northpark and at LPH working together. This is reflected in the Northpark and LPH Consumer and Diversity Engagement Plan 2020-2024, with a planned review scheduled for 2024. | |
| **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 Healthscope Patient Rights and Responsibilities policy is the reference document for LPH.<br><br>LPH demonstrated that the Charter of Rights is readily available and has been translated into four languages selected following a review of local population demographics. There are plans for additional translations.<br><br>Consumers interviewed across day surgery and the surgical ward confirmed that they were aware of the Charter and understood the information. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.04 | |
|---|---|
| The health service organisation ensures that its informed consent processes comply with legislation and best practice | |
| **Comments** | |
| Interviews with LPH staff showed that they understood their responsibilities with respect to informed consent. The relevant Healthscope consent policy, 'Consent to Medical / Surgical Treatment' complies with legislation, and references best practice. There are a range of Healthscope consent policies available to LPH (e.g. the use of photographs). The assessors reviewed health records and the completed consent forms. Consent forms will be audited as part of the scheduled April – June 2024 audits.<br><br>The Healthscope 'Admission of Patients and Informed Financial Consent' policy is clear and has been implemented at LPH. LPH has met the requirements of Advisory AS18/10. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.05 | |
|---|---|
| The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves | |
| **Comments** | |
| A review of documentation showed there are processes in place to establish a patients' capacity to make decisions regarding their own care, and includes the process to be followed if a substitute decision-maker is required. Staff were able to discuss the consent policy, the processes, and the relevant sections on the consent form for a substitute decision maker. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.06 | |
|---|---|
| The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care | |
| **Comments** | |
| Interviews with consumers and clinicians confirmed that staff work with consumers and facilitate shared decision-making about their care planning and goals of care. These were documented in the medical records and on each Care Board in the patient bedrooms. This included overall goals of care, and also daily goals. The decision to include daily goals was the result of the Consumer Consultant review and input, including contacting other services for examples of the content of boards in other facilities. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.07 | |
|---|---|
| The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care | |
| **Comments** | |
| Staff were able to describe to the assessors how consumers are actively involved in their care. Consumers confirmed that this was their experience and through observation it was evident that staff facilitated their participation. A review of surgical ward data to date showed that 82% of consumers who had responded to the Healthscope-wide patient experience survey reported being engaged in their treatment and care decision-making. This information was also present on the Quality and Safety Board in the surgical ward. The data had been updated daily but reporting for the ward, peri-operative department, and theatres will occur on a monthly cycle in line with Northpark and Healthscope sites. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.08 | |
|---|---|
| The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community | |
| **Comments** | |
| A review of information provided to consumers through a wide range of mechanisms demonstrated that significant action has been undertaken to align communication with the needs of a diverse population, and with consumers, carers, and their families.<br><br>There was no single policy or reference document about health literacy sighted, however, the commitment to ensuring that consumers and their next-of-kin understand information and communications is reflected in other policy documents. Healthscope has 'search for a surgeon' tool with VMO profiles, including languages spoken, and pre-admission data includes self-identification, including country of birth, primary languages, and religion. | |
| **Suggestion(s) for Improvement** | |
| The need for interpreters was not clear, however, there was a Healthscope Interpreter Service policy. It is suggested that the accessibility and use, if required, of the interpreter service, and its compliance with the policy is considered in the context of what is an accumulating LPH specific consumer profile. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.09 | |
|---|---|
| Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review | |
| **Comments** | |
| Documentation reviewed by the assessors as well as discussions with staff confirmed that any internally developed information had been reviewed by consumers, which was in line with the Healthscope Consumer Approved Publications (CAP) policy.<br><br>All reviewed documentation included the CAP logo, showing that each had been reviewed by consumers. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.10 | |
|---|---|
| The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge | |
| **Comments** | |
| Clinicians were able to explain to the assessors how they effectively partner with consumers in their own care, and how they work with consumers to support their ongoing care needs, including preparation for discharge. Consumers interviewed by the assessors reported the information provided to them was timely and provided in a manner and format they understood. Discharge summaries were reviewed and appeared complete and specific to the needs of the patient. This included the input of the physiotherapist and arrangements for equipment and its safe use in the home. | |
| **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 staff interviewed in relation to the direct input of consumers into the design and refurbishment of the LPH site. were all recent engagements, including the Executive. There was a reported commitment to routinely involve consumer consultants through the yet-to-meet Consumer Consultant Committee. The LPH consumer consultant had been pivotal in the review of the layout and content of the Care Boards, which were in place and being used by staff, consumers, and carers.<br><br>The Consumer Consultation Committee and the Quality and Risk Committee include consumer consultant membership in the Terms of Reference.<br><br>LPH has access to the Healthscope consumer groups, including the national cultural diversity group. | |
| **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** | |
| The consumer consultant interviewed by the assessors was aware of the Healthscope-required Foundations training program and had completed two of the four modules. There was planned orientation to the scheduled Consumer Consultation Committee and the Quality and Risk Committee.<br><br>The consumer consultant told the assessor that he felt very supported and was confident that additional support would be provided if he sought it. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 2.13 | |
|---|---|
| The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs | |
| **Comments** | |
| The draft Aboriginal and Torres Strait Islander Engagement Plan reflects the intent of LPH to engage with the local communities, and staff outlined some of the projects they are aiming to deliver in partnership. | |
| **Suggestion(s) for Improvement** | |
| The Aboriginal and Torres Strait Islander Engagement Plan and Quality Plan both include engagement with local Aboriginal and Torres Strait Islander communities; however, what was not clear was the degree of Executive involvement in developing the partnerships. It is suggested that before the draft Aboriginal and Torres Strait Islander Engagement Plan is finalised, that this is reviewed. | |
| **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 draft Consumer Engagement Plan reflects the LPH commitment to establish a Consumer Consultant Committee (draft terms of reference and agenda were available). In addition, there are plans for the consumer consultant to complete direct surveys / interviews and to be involved in workforce training The assessors observed that the consumer consultant was recognised and was engaged with staff. The electronic Healthscope Patient Portal has already provided experience data that can be accessed by staff in real time. What data was available to the surgical ward had been recorded on the Safety and Quality Board in the ward. There had been consumer input and review of many of the Healthscope eLearning modules that staff are required to complete. | |
| **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** | |
| HICMR Infection Prevention and Control policies and procedures have been implemented. These guide practice, risk management, and assist to determine training requirements for preventing and controlling healthcare-associated infections, and attending to antimicrobial stewardship. Staff were able to describe how they operationalise infection control policies and procedures, how associated risks will be managed, and were also able to describe the training provided regarding antimicrobial stewardship and preventing and controlling healthcare-associated infections. There had been no reported HIA reportable infections at the time of the assessment. | |
| **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** |
| A multidisciplinary Infection Prevention and Control (IPC) Committee has been established to oversee infection prevention and AMS. It is also planned to provide reports to the Medical Advisory Committees. The terms of reference of the IPC committee states that the committee is responsible for monitoring and improving infection prevention, evaluating both the effectiveness of the surveillance system and workforce training. Monthly reporting to the national Healthscope Infection Prevention and Control Committee is scheduled. A qualified IPC nurse will provide education, monitoring, and reporting expertise, and an HICMR consultant will also contribute to education and auditing.<br><br>The Covid-19 Plan, based on Victorian Department of Health protocols, includes a risk-based tiered response approach that is responsive to the community-based risk level. |

| 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 planned, comprehensive infection prevention and control audit schedule, and audit results will be provided to individual treatment (craft) groups. Aggregate data will be provided through the governance structure. Infection control and prevention and antimicrobial stewardship are discussed at relevant committee meetings, and strategies will be documented to improve performance if gaps are identified in the future. An infectious diseases (ID) physician attends the hospital weekly and as a function of the role, collects information on antibiotic use and follows up any anomalies with prescribers. External expertise from HICMR will be utilised to evaluate the effectiveness of the IPC system. |

| 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** |
| Staff were able to describe the actions taken to involve and inform patients regarding infection prevention and control and AMS measures. Information is available to patients, carers, and families in a format that is easily understood, including translated brochures. There were no patients on parenteral antimicrobials at the time of the assessment, however the ID physician, who will review all patients on antimicrobials, has been appointed. |

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

| ACTION 3.05 |
|---|
| The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups |
| **Comments** |
| The organisation aims to monitor and collect data on healthcare-related infections and antimicrobial use, as well as broader infection control surveillance data. Reports on healthcare-related infections and antimicrobial use will be provided to clinicians and reported through the clinical governance structure in the near future. Current data sets that support the effectiveness of the organisation's strategies include superficial skin reactions, line-associated infections, and other invasive device or procedure-related infections, as well as transmission between staff and patients.<br><br>Indicators mandated by the Victorian Safer Care Department (VICNISS) are also reported. . |

| 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 the Infection Control Policy 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 those developed by the ACSQHC. |

| 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** |
| The Infection Control policy and processes for management of organism-specific risks, including prevalence in the community, are in place and are consistent with jurisdictional and Public Health advice. In response to Victorian infection risk/s present in the communities served by the organisation, a tiered organisation response has been developed and is in place. Handover, transfer of care, and discharge processes include the requirement for documentation and communication of infectious status. Brochures, posters, and pre-admission information are utilised to advise patients, carers, and visitors on infection control and management processes.<br><br>A competency-based training program is in place for the appropriate use of standard and transmission-based precautions. PPE fitting and training in its use has been attended by 100% of the workforce. A HICMR audit tool is available to audit transmission-based precautions (TBP). |

| 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 have been established 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. Environmental management and cleaning practices are consistent with policy. Most overnight patients are cared for in single rooms. There is a multi-bed HDU planned, with single rooms adjacent to its location, if required. There were no patients requiring TBC during the assessment. |

| 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, and compliance will be monitored through observational audits. Patients, carers, families, and visitors are alerted to required precautions, with posters describing the required precautions at the entry to patient care zones, while brochures are also available on PIVC, HAC, and Cough Etiquette. The electronic admission site WebPas is also used to record alerts. |

| 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. The organisation has access to hand hygiene auditors. HH education completion was 83% at the time of the assessment.<br><br>Three compliance and observational audits are planned annually to be undertaken and reported. |

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

| ACTION 3.11 |
|---|
| The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique |
| **Comments** |
| Procedures requiring the use of aseptic technique, including line management, simple and complex dressing, catheterisation, and access VADs. Nursing staff are appropriately trained in accordance with the skills matrix. At the time of the assessment, completion of ANTT education was reported at 50%, with the target of 92%. Compliance monitoring will be undertaken regularly. |

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

| ACTION 3.12 | |
|---|---|
| The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare | |
| **Comments** | |
| Training and assessment in the management of invasive devices is available to staff and aligns with the current best practice. Line-associated infection rates will be monitored and reported. | |
| **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 procedures and schedules are in place, with regular in-house auditing scheduled. 100% of the workforce has completed training on cleaning processes for routine, outbreak situations, and novel infections. Spill kits were observed to be available in several locations. There is an external contract in place for after-hours cleaning of the Operating Suite. | |
| **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** | |
| Infection control processes, policies, and procedures include responding to infection risks for equipment, devices, products, buildings, and linen. All new products are reviewed and assessed for infection-related risk. In-house maintenance is scheduled, and is also conducted in response to failure. Furnishings and fittings were noted to be of high quality. Carpet was noted to be in all patient rooms with the exception of the HDU.<br><br>Linen was observed to be protected from environmental contamination. | |
| **Suggestion(s) for Improvement** | |
| Consider removing carpet from some rooms for use as isolation rooms. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 3.15 | |
|---|---|
| The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients | |
| **Comments** | |
| There is a comprehensive workforce immunisation program in place that complies with the Victorian jurisdictional policy and national guidelines. Immunisation status is captured during the recruitment process. Staff immunisation status is captured during onboarding. | |
| **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** |
| Covid vaccination is mandated by the Victorian Department of Health. 100% of the workforce are fully vaccinated for Covid-19.<br><br>Policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce are in place. Records of workplace allocation include both appointed, rotating, and consultant staff. The program for workforce screening and workplace exclusion is aligned with Vic Health directions. Welfare checks for staff on illness leave are conducted by line managers.<br><br>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** |
| The sterilising and endoscopy reprocessing area is located at Northpark Private Hospital. Procedures for point of use cleaning and transporting to the offsite location were observed. Traceability and monitoring are fully compliant with management processes described in the Reprocessing Standard. Reprocessing procedures include management of novel infections. |

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

| ACTION 3.18 |
|---|
| The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement |
| **Comments** |
| The organisation has established an antimicrobial stewardship program that is guided by evidence-based policy and tailored to the service scope. Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use. |

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

| ACTION 3.19 | |
|---|---|
| The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials | |
| **Comments** | |
| Documentation showed that in establishing the antimicrobial stewardship program, the review of antimicrobial prescribing and use and surveillance data on antimicrobial resistance was considered. All AM prescriptions for inpatients are to be monitored during the ID rounds. Clinicians were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance will be used to support appropriate prescribing. SNAPs and NAPs audits are planned for October 2024. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 4 - Medication Safety

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

| **ACTION 4.01** | |
|---|---|
| Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management | |
| **Comments** | |
| The governance of medication management is defined by the Medication Orders and Administration policy and associated procedures that apply a risk-based approach to effectively minimising incidents and harm. Staff have been provided with online medication management training that is commensurate with their roles. Medication management is currently overseen by the Quality Committee, however the draft TOR for the Medication Safety Committee were reviewed, and it is also planned to provide reports to the MAC and to staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| **ACTION 4.02** | |
|---|---|
| The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management | |
| **Comments** | |
| The organisation plans to monitor the effectiveness of the medication management system through incident reporting and pharmacist medication reviews. No medication incidents have been reported to date. | |
| **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** | |
| Patients participate in their medication management from pre-admission and throughout their admission. Nurses and pharmacists provide appropriate information about medications and treatments. Patients were observed providing their medication history during admission. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.04 | |
|---|---|
| The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians | |
| **Comments** | |
| Scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians. As described in policy, nurse-initiated, over the counter medications can be administered once. | |
| **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 by nurses on admission and is documented in the clinical record. Compliance with completion of the BPMH will be audited. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.06 | |
|---|---|
| Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care | |
| **Comments** | |
| Interviews with clinicians, together with a review of documentation and observations made by the assessors, confirmed that current medications are reviewed for accuracy and congruence with the best possible medication history by the clinical pharmacist. | |
| **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. Records reviewed by the assessment team confirmed their use. Ongoing compliance with documenting medication-related alerts will be monitored by pharmacists. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.08 | |
|---|---|
| The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system | |
| **Comments** | |
| Adverse drug reactions will be reported through the incident management system, and managers stated they are aiming to build a strong culture of reporting incidents and near misses. Medication-related incidents will be reviewed by the line managers, and automated reporting will occur in accordance with severity. No such reports had occurred at the time of the assessment. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.09 | |
|---|---|
| The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements | |
| **Comments** | |
| The organisation has established processes for reporting adverse drug reactions to the TGA by the pharmacy, where required. To date there have been no notifications. | |
| **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 referring to risk and clinical need. Responsible clinicians, including pharmacists, were able to describe this process, how it is documented, and how action taken in response to the review are followed though. Pharmacists will be involved based on a risk approach. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.11 | |
|---|---|
| The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks | |
| **Comments** | |
| Information for patients on specific medications is available to clinicians and appropriate to the patient population. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

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

| ACTION 4.13 | |
|---|---|
| The health service organisation ensures that information and decision support tools for medicines are available to clinicians | |
| **Comments** | |
| Clinicians have access to information and medication management support tools via mobile devices and computers in each area. Clinicians reported being able to readily access this information. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.14 | |
|---|---|
| The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines | |
| **Comments** | |
| Pharmacists monitor 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 to be reported through the incident management system. No such breaches have occurred to date. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 4.15 | |
|---|---|
| The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely | |
| **Comments** | |
| High risk medications are clearly identified, and there is an appropriate management system in place for the storage, dispensing, and administration of those medications. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 5 - Comprehensive Care

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

| **ACTION 5.01** | |
|---|---|
| Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care | |
| **Comments** | |
| Healthscope has an extensive range of policies to support and guide compliance with Standard 5, including the Comprehensive Care Plan, Comprehensive Risk Screening Tool, Diet and Nutrition – Adult Patients, and Falls Prevention and Management. The implementation of the 2024 audit schedule will provide a system for monitoring of compliance with the policy requirements.<br><br>Multi-disciplinary team members were able to describe how safety and quality systems are used, and the clinical documentation that supports those systems is in place. Training regarding the individual policies is established, and the Healthscope Comprehensive Care specific training program, which is in development, will be available to LPH once completed. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.02 | |
|---|---|
| The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care | |
| **Comments** | |
| The Healthscope Comprehensive Care Plan Policy and evidence-based practice inform LPH service development, models of care and consumer journeys. The accumulating feedback, data and outcomes of care is being collected by LPH to inform future improvements.<br><br>The 2024 audit schedule includes pressure injuries, falls, assessment, care planning, and physical health needs. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.03 | |
|---|---|
| Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making | |
| **Comments** | |
| The Comprehensive Care Plan Policy outlines the requirements for actively involving consumers in their care with shared decision-making.<br><br>The assessors interviewed consumers who reported that they had been actively involved in the planning of their care and treatment, and clinicians described the ways they enabled this active participation. This was reflected in the Care Boards and daily care plans. | |
| **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 were supported to establish comprehensive plans for consumer care and treatment, and this was clearly stated in the Healthscope Comprehensive Care Plan Policy.<br><br>The clinician with overall accountability for a patient's care is defined as the VMO, and there are systems in place to cover both business and after-hours accountability.<br><br>Care was provided in the most appropriate setting available. | |
| **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** | |
| Clinicians worked as part of a multidisciplinary team, and the assessors observed collaboration and teamwork in action during their visits to clinical areas. There were defined roles, and clinicians were able to describe how the multi-disciplinary team worked.<br><br>The feedback from staff was very positive regarding the collegial nature of the clinical teams in meeting a consumer's needs. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.06 | |
|---|---|
| Clinicians work collaboratively to plan and deliver comprehensive care | |
| **Comments** | |
| Clinicians and consumers described how they work collaboratively to plan and deliver comprehensive care. This was supported by clinical documentation and observed in multi-disciplinary meetings and during observed transfers and clinical handovers. | |
| **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 aimed at minimising preventable harm are in place to screen and assess patients for risks. LPH utilises the Healthscope Comprehensive Risk Screening Tool. Clinicians were able to describe the risk assessment process, and evidence of this was sighted in clinical documentation. The assessors observed the completion of the risk screening during a preoperative admission. Comprehensive risk screening is on the audit schedule, and the NUMs are routinely reviewing the completion of the screenings and the actions undertaken.<br><br>The organisation was compliant with the requirements of Advisory AS18/14. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.08 | |
|---|---|
| The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems | |
| **Comments** | |
| LPH had processes in place to identify Aboriginal and Torres Strait Islander consumers. The information was recorded in administrative and clinical information systems. 'Asking the question' training had been completed with staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.09 | |
|---|---|
| Patients are supported to document clear advance care plans | |
| **Comments** | |
| There are processes to assist a consumer to document an Advance Care Plan. LPH has training for staff regarding advance care planning, and there is a system for recording, accessing, and alerting staff to a completed Advance Care Plan, however, to date LPH has not admitted a consumer with an Advance Care Plan.<br><br>The organisation was compliant with the requirements of Advisory AS18/14. | |
| **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 on admission and builds on the online or paper-based preadmission registration. The assessment can be repeated when clinically indicated and includes screening for a range of risks, including cognitive, behavioural, mental health, physical health, and the social and other issues that may compound risk. The clinical documentation reviewed by the assessors supported this. Risk screening processes are included on the 2024 audit schedule.<br><br>There is an ongoing process of evaluating the assessments and risks through multidisciplinary clinical team reviews, which includes documenting whether treatments and interventions are effective or not.<br><br>The organisation was compliant with the requirements of Advisory AS18/14. |

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

| ACTION 5.11 |
|---|
| Clinicians comprehensively assess the conditions and risks identified through the screening process |
| **Comments** |
| Risks are identified using the Healthscope Comprehensive Risk Screening tool, which is guided by the Clinical Risk Management policy, and includes standardised screening tools. . Clinical roles are identified regarding the reporting, completion, and review of the results and outcomes of identified actions. Policies about clinical assessment include the requirements and training that clinicians should complete. The outcomes of assessments were discussed at multidisciplinary clinical reviews, and additional assessments undertaken, when required. |

| 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** | |
| The Healthscope Alerts – Documentation and Management policy outlines the requirements for documenting assessments, risk screening, and the notations for alerts. The assessors reviewed the medical records in the LPH surgical unit and perioperative services and noted that these were clearly documented and, if there was no alert, this was also documented. Multidisciplinary team and nursing handovers observed by the assessors were very comprehensive, including noting consumer alerts in the health record and medication charts. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.13 | |
|---|---|
| Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence | |
| **Comments** | |
| Clinicians were able to describe how they worked with consumers and families to determine agreed goals of care, including the identification of risks. They showed a thorough understanding of the processes. A review of the clinical documentation demonstrated that comprehensive discharge planning is initiated as early as possible in the consumer's journey. The assessors observed interactions between clinicians, patients and their families that demonstrated a partnership in shared decision-making. The Healthscope care planning and care plan policy reflected contemporary evidence-based and best practice principles.<br><br>Monitoring and evaluation of the outcomes of LPH comprehensive care planning processes is undertaken through clinical reviews. Reporting and analysis of aggregated data will occur through the 2024 audit schedule.<br><br>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** | |
| Care plans are developed with the consumer and multidisciplinary team and are reviewed daily at LPH. Admissions to date have been short, and the daily and sometimes twice daily reviews were evident in the health records with the goals of care modified and updated in the care plan and on the Care Boards. Feedback from consumers and families described their experience of active participation in decision-making at all points of care and transitions.<br><br>Monitoring and evaluation of the outcomes of LPH comprehensive care planning processes is undertaken through clinical reviews. Reporting and analysis of aggregated data will occur through the 2024 audit schedule. | |
| **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** | |
| LPH has not experienced any end-of-life care needs to date and there was an understanding that if this identified as a need, it is likely the consumer would, in consultation with the family and multidisciplinary team, be transferred to a more appropriate service.<br><br>In addition, there was a pathway to palliative care specialist services, and, if required, to social work services. The Healthscope End-of-Life Toolkit was available on the surgical unit, and clinicians understood the referral pathways and how to make referrals, and how to use the Toolkit. | |
| **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** | |
| As noted in 5.15, LPH has not experienced any end-of-life care needs to date and there was an understanding that if this identified as a need, it is likely the consumer would, in consultation with the family and multidisciplinary team, be transferred to a more appropriate service. Staff at LPH would liaise with specialised palliative care clinicians should the need arise. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.17 | |
|---|---|
| The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record | |
| **Comments** | |
| There are processes for the acceptance of an advance care plan from a consumer. Clinicians were clear about where to access an advance care plan in the health record. To date, LPH has not admitted a consumer with an advance care plan. | |
| **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** | |
| Clinical supervision is available, and would support staff who may be providing end-of-life care. Access to social work was also identified as a source of support for staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.19 | |
|---|---|
| The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care | |
| **Comments** | |
| The process for recording the goals of care for a consumer requiring end-of-life care is a component of the Healthscope Comprehensive Care Planning, and according to clinicians, this is subject to the same systems of review in the context of specialist advice. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.20 | |
|---|---|
| Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care | |
| **Comments** | |
| LPH supported shared decision-making about end-of-life care with consumers, their carers, and families. This was reflected in the Healthscope End-of-Life Toolkit which was consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.21 | |
|---|---|
| The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines | |
| **Comments** | |
| LPH utilised Healthscope evidence-based policies and procedures for pressure injury prevention and wound management. These are well referenced and regularly reviewed. Monitoring will be undertaken by the Quality and Risk Committee when it commences. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.22 | |
|---|---|
| Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency | |
| **Comments** | |
| Skin inspections are conducted in accordance with policy and recorded on the Comprehensive Risk Screening, and there is a pathway for referral to wound care specialists. | |
| **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** | |
| Clinicians have access to information for consumers and families about pressure injury prevention. Clinicians described processes which guide the assessment of pressure injuries and explained that the consumer and carers were involved, and that education about prevention was provided. Equipment, products, and devices were available to prevent and manage pressure injuries. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.24 | |
|---|---|
| The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management | |
| **Comments** | |
| The Healthscope Patient Falls Prevention and Management policy included strategies such as supervision, assessment, responding to risks, involvement of allied health, and the scanning of environmental factors to reduce risk potential and to prevent and manage falls.<br><br>Evidence-based policies and procedures include risk assessment, prevention, harm minimisation, and post-falls management. Compliance with undertaking falls risk assessments and falls management action plans will be audited as part of the 2024 audit schedule. | |
| **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** | |
| Clinicians have access to risk assessment tools and equipment to assist in the prevention and management of falls. Equipment, devices, and strategies to prevent falls and minimise harm from falls are available to staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.26 | |
|---|---|
| Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies | |
| **Comments** | |
| Information is available to consumers and families about falls prevention and risk management strategies. This information is user-friendly and has a CAP logo. | |
| **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** | |
| Consumers are assessed for nutritional needs and risk of malnutrition. The assessors saw evidence of this screening and interviews with staff confirmed their understanding of the process. Healthscope is currently reviewing the policy about nutrition, including training requirements. | |
| **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** |
| LPH provided nutritional support to consumers as identified through risk screening. The process for providing care to a consumer who is identified as being at risk of malnutrition or who requires assistance with eating and / or drinking was described by clinicians. There is a referral pathway to a dietitian, and special dietary plans are available when risks are identified. Food and fluid intake is monitored, recorded, and discussed at the multidisciplinary reviews if the patient is at risk of not having their nutritional needs met. |

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

| ACTION 5.29 |
|---|
| The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation |
| **Comments** |
| The Healthscope Delirium and Cognitive Impairment Prevention and Management Policy operationalises the ACSQHC Delirium Clinical Care Standard, and identified a range of performance indicators that LPH will report on.<br><br>The requirements of the AdvisoryAS22/01 and ACSQHC Fact Sheet 11 (5.29a) were assessed as met. |

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

| ACTION 5.30 | |
|---|---|
| Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care | |
| **Comments** | |
| Documentation showed that systems are in place to care for consumers with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken through the Healthscope Comprehensive Risk Screening process. Compliance will be monitored through the 2024 audit schedule. Staff were able to describe how they collaborate with consumers and families when caring for a consumer with cognitive impairment. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.31 | |
|---|---|
| The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed | |
| **Comments** | |
| Strategies and screening tools are in place to identify consumers at risk of self-harm and / or suicide. If a consumer at LPH was assessed as being at risk, they can be transferred to an appropriate specialist facility; however, there were pathways to specialist services onsite. | |
| **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** | |
| Processes for follow up of consumers who have expressed thoughts of self-harm or experienced deliberate self-harm were available. Staff were able to describe how they would access the specialist pathway, including Northpark, which has specialist mental health teams. | |
| **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** | |
| LPH and Healthscope training has a focus on de-escalation and had been completed by a high proportion of staff. Healthscope policies that support the identification, mitigation, and management of aggression are current and accessible to staff. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.34 | |
|---|---|
| The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce | |
| **Comments** | |
| The organisation has strategies and processes in place to identify patients at risk of becoming aggressive, including de-escalation strategies. The processes to manage aggression aim to minimise harm to consumers, carers, families, staff, and visitors. Staff were able to describe how they work with consumers and others to implement these strategies. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 5.35 | |
|---|---|
| Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body | |
| **Comments** | |
| The Healthscope Restrictive Practices – Patient Restraint (Non-Mental Health Environment) is accessible and understood by clinicians. The use of constant supervision was noted as a restrictive practice. It had not been used at LPH but staff were clear about the requirements for monitoring, reporting, and recording its use. | |
| **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** | | |
| Not Applicable. | | |
| **Rating** | **Applicable HSF IDs** | |
| NA | All | **NA Comment:**<br>Non gazetted service, does not use seclusion.<br>**Verified During Assessment:** Yes<br>**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 policies are in place to support effective clinical communication, including bedside handover. These policies identify risk management strategies, the training requirements, and the expectation of all staff in support of effective clinical communication. The assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| **ACTION 6.02** | |
|---|---|
| The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes | |
| **Comments** | |
| Incidents relating to failure in clinical communication are reported through the incident management system RiskMan and are subject to review and investigation. LPH intends to utilise the accumulated data to inform improvements and changes in communication strategies and processes. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 6.03 | |
|---|---|
| Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making | |
| **Comments** | |
| The Healthscope Comprehensive Care Plan and Departmental and Intra-Unit Clinical Handover policies –require the use of ISBAR and are clear about the requirement for the engagement of consumers and families in their own care and shared decision-making. The assessors observed consumers involved in bedside clinical handover and at transition points. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

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

| ACTION 6.05 | |
|---|---|
| The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated | |
| **Comments** | |
| The Healthscope Correct Patient, Correct Procedure, Correct Site policy defines the use of three approved identifiers. Staff told the assessors how and when these were used. The assessors observed the identifiers being used in handovers and at transfers between departments. Compliance will be audited, monitored, and reported as scheduled. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 6.06 | |
|---|---|
| The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care | |
| **Comments** | |
| The assessors noted the use of approved patient identifiers as noted in Action 6.5, and the time-out process was observed, and is documented. A review of health records showed evidence that the process was being used. Compliance will be audited, monitored, and reported as scheduled. | |
| **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** | |
| LPH clinical handover documentation contained the relevant risks and needs of the consumer. Staff could explain their respective roles in bedside clinical handover and at transfers between departments, including the minimum information communicated. The assessors observed bedside handovers and transfers between departments that complied with the stated requirements, including involving the consumer in determining their goals and preferences, and identifying the responsible clinician. | |
| **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 assessors observed staff in clinical handover that was structured using the ISBAR tool, and effectively engaged with consumers in defining goals of care and shared decision-making. The processes in place for clinical handover ensured that the relevant clinicians were actively engaged in the process. | |
| **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** | |
| Healthscope and LPH had policies and procedures to guide staff in effective communication and handover of critical information, including risks and alerts. Consumers and staff described how it worked and how consumers and families were involved. | |
| **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** | |
| The involvement of families and carers in communicating critical information is part of the admission process and documentation. The clinicians in pre-operative clinics and operating theatres were proactive in contacting family and carers, with consumer consent. The surgical ward was also very engaged with their consumers' families. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 6.11 | |
|---|---|
| The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan | |
| **Comments** | |
| Clinical documentation reviewed by the assessors confirmed compliance with Healthscope processes for complete, accurate, and up-to-date information in the paper-based healthcare record and the electronic system. Members of the clinical team described how it worked. Comprehensive clinical documentation audits are scheduled, and the documentation is reviewed by the senior nursing staff in the interim. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 7 - Blood Management

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

| **ACTION 7.01** | |
|---|---|
| Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management | |
| **Comments** | |
| Policies and procedures provided by the contractor Melbourne Pathology are in place for blood management and the management of associated risks. No transfusions have yet been administered. Blood administration clinical skills training is being completed as nursing staff join the team. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| **ACTION 7.02** | |
|---|---|
| The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management | |
| **Comments** | |
| The hospital has established processes, in partnership with the Melbourne Pathology, to monitor the blood management process in terms of blood and blood product use, quality and safety, and patient outcomes. Reports are to be provided to the Patient Care Review Committee including serious transfusion incidents. Transfusions will be audited in accordance with National Guidelines. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.03 | |
|---|---|
| Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making | |
| **Comments** | |
| The engagement of consumers in care decisions related to blood management will be included in the informed decision-making process for transfusion. National blood safe resources have been utilised to make information available in multiple languages. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.04 | |
|---|---|
| Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks | |
| **Comments** | |
| LPH has transfusion policies, processes, and guidelines which support the clinically effective and efficient use of blood and blood products, including single unit administration. Utilisation is planned to be monitored and waste is anticipated to be minimal. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.05 | |
|---|---|
| Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record | |
| **Comments** | |
| The assessors reviewed documentation that will be completed for patients receiving blood and blood products. No transfusion of blood or blood products has occurred to date. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.06 | |
|---|---|
| The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria | |
| **Comments** | |
| The transfusion guidelines are consistent with the national guidelines and national criteria for the prescription and administration of blood and blood products, and these are available to clinicians. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.07 | |
|---|---|
| The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria | |
| **Comments** | |
| Processes are in place for the reporting of adverse events related to transfusions. These will be reported through the pathology provider to the Quality Committee. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.08 | |
|---|---|
| The health service organisation participates in haemovigilance activities, in accordance with the national framework | |
| **Comments** | |
| The organisation plans to contribute to national haemovigilance activities. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.09 | |
|---|---|
| The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer | |
| **Comments** | |
| Two units of Type O Neg Blood are stored on site, and these will be rotated to Melbourne Pathology to ensure viability. All products will be traceable. Any incident related to inappropriate handling of blood or blood products will be reported and managed through the incident management system. No incidents have been reported yet. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 7.10 | |
|---|---|
| The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage | |
| **Comments** | |
| Processes and arrangements are in place with Melbourne Pathology to manage the availability of blood and blood products, eliminate wastage, and respond to shortages. The use of blood and blood products will be monitored and reported through to the Senior Leadership team. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Standard 8 - Recognising and Responding to Acute Deterioration

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

| **ACTION 8.01** | |
|---|---|
| Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration | |
| **Comments** | |
| There is an LPH Local Policy (LP2.01 Clinical Deterioration, Rapid Response and Escalation) which outlines the processes for LPH. The Standard 7-8 sub-committee, which is yet to meet, will provide monitoring and oversight of this area, and report to the Quality and Risk Committee. The LPH policy is current, and the workforce appear to understand their responsibilities within the escalation processes and reported that they had access to resources and had completed training. | |
| **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** | |
| Monitoring the effectiveness of the systems for identifying and managing acute deterioration takes place through the Healthscope system, with the LPH committees to meet as scheduled. There is yet to be a MET call or Code Blue, but staff are clear about the requirement for reporting and review should one occur. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 8.03 | |
|---|---|
| Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making | |
| **Comments** | |
| The assessors observed staff partnering with consumers in recognising and responding to acute deterioration. This included involving patients directly in their care with shared decision-making based on an assessment of their information needs. Consumer and clinician interviews, and a review of the healthcare records confirmed that active involvement in planning and decision-making about the management of acute deterioration occurs at LPH. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 8.04 | |
|---|---|
| The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient | |
| **Comments** | |
| Vital signs are monitored according to Healthscope policy, and the standard adult general observations chart (SAGO) was routinely used and appeared to be complete when reviewed. Observations had been undertaken in response to a consumer's circumstances and with documented parameters, and there was a process for recording a change to parameters. | |
| **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** |
| Strategies and pathways have been defined and staff understand their use in circumstances of an acute deterioration in mental state. The assessment process promotes discussion with consumers to identify if they are at risk of deterioration, and to identify the level of support required. If a consumer at LPH was determined to be at risk, there are referral pathways to specialist services and the onsite physician, or they may be transferred to an appropriate specialist facility. |

| 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** |
| LPH Local Policy (LP2.01- Clinical Deterioration, Rapid Response and Escalation) articulates the criteria for escalating care in circumstances of acute physiological deterioration, mental status, pain and distress, and concerns raised by staff, consumers, and families. The policy is current and references best-practice and the Healthscope policy. There is an onsite response to Met Calls and Code Blue. Staff explained the process for the escalation of care, and consumers were able to explain who to contact should they require assistance.<br><br>The requirements if Advisory AS 19/01 have been met. |
| **Suggestion(s) for Improvement** |
| RiskMan does not have a category for REACH incidents, and it was unclear how they will be reported. A review of the incident reporting system is suggested, to determine if it will meet the needs for monitoring and reporting of REACH incidents. |

| 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** | |
| LPH has implemented the REACH system, which is not specified as the required tool by Healthscope. The consumer consultant was involved in the development of the project and the posters, and staff have been provided with education. The REACH contact number is on the Care Board in each bedroom and on posters around the surgical ward and other areas. There has been one REACH call made, which received appropriate follow-up and escalation that was discussed in detail with the assessors. The call was recorded in RiskMan and will be subject to investigation and review. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 8.08 | |
|---|---|
| The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance | |
| **Comments** | |
| The LPH Local Policy (LP2.01 - Clinical Deterioration, Rapid Response and Escalation) provided direction for staff to escalate care and respond to a clinical emergency. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 8.09 | |
|---|---|
| The workforce uses the recognition and response systems to escalate care | |
| **Comments** | |
| Staff were able to describe the LPH Local Policy (LP2.01 - Clinical Deterioration, Rapid Response and Escalation). There has been training and testing of the system, but there has been no requirement for the system to be activated in direct clinical care yet. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

| ACTION 8.10 | |
|---|---|
| The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration | |
| **Comments** | |
| Education was provided to clinicians about the timely and effective response to and management of consumers who experience an acute deterioration. | |
| **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** | |
| LPH had high levels of advanced life support skills and competency amongst clinicians. This had been a focus of the pre-opening training. | |
| **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** | |
| Processes are in place for the rapid referral of consumers who have expressed or exhibited a deterioration in their mental state. Staff were able to describe how they would access the specialist pathway, including referral to NorthPark, which includes specialist mental health teams. | |
| **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** | |
| LPH Local Policy (LP2.01 - Clinical Deterioration, Rapid Response and Escalation) articulates the criteria for escalating care in circumstances of acute physiological deterioration. There is an onsite response to Met Calls and Code Blue, and access to an onsite physician until evening. The effectiveness of escalation of care systems will be audited, monitored, and reported to the Quality and Risk Committee. | |
| **Rating** | **Applicable HSF IDs** |
| Met | All |

# Recommendations from Previous Assessment

NIL.