NSQHS Standards 2nd Edition Assessment Healthscope - Brisbane Private Hospital 101148

Accreditation Status	*Accredited*
Date(s) of Assessment	*12/02/2024 - 14/02/2024 (Initial)* *07/05/2024 - 07/05/2024 (Final)*
Site	*259 Wickham Terrace Spring Hill QLD 4000*
Scope of certification	*The provision of acute adult surgical and general medical, child surgical services, pain management, adult rehabilitation and mental health services*

Details and Registration of the Health Service
Qld Health Licence QDH1026/39 4/10/2023 - 30/09/2024
Medication Licence Approval 35030Q for Slade Pharmacy dated 4/12/2023
Fire Inspection Letter for Building #3 26/5/2023
Brisbane Private Hospital 11/4/2023
Food Authority Licence A006171345 27/2/23 - 26/2/2024
Radiation Safety Act Possession Licence Expiry date 31/10/2024

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

Contents

ABOUT THE COMMISSION

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

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

THE AHSSQA SCHEME

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

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

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

RATING SCALE DEFINITION

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

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

Suggestions for Improvement

The assessment team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating.

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

ACCREDITING AGENCY

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

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

Conflicts of Interest

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

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

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

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Brisbane Private Hospital
The outcome for this assessment is	Accredited
Date of accrediting agency determination	18/05/2024
Date health service organisation notified	18/05/2024
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

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

5.15, 5.16, 5.18, 5.19, 5.20, 5.36

Has the assessor verified actions were not applicable during the assessment	Yes
Have any actions not complying with Advisory 18/01 been approved by the Commission	NA

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

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	Yes Six incidents from 2023 and 2024 were tabled at the opening meeting. One anonymous report was made to the Office of the Health Ombudsman. File No#161151 from 23/10/2023 noted the complaint was investigated with no further action required by Qld Health PHRU.
Has there been any inspections/audits by regulators?	Yes Queensland Health Inspection Report noted.

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements.	Yes
Patient Episode	During the assessment the assessment team had the opportunity to visit a number of clinical areas and observe various aspects of patient episodes of care.	Yes

Requirement	Assessment Outcome	Complies
	Clinical areas sampled include Day Surgery Unit, Endoscopy Unit, Main Operating Theatre, CSSD, Intensive Care Unit and General Surgical Ward B. DSU consists of two procedure rooms with an endoscopy reprocessing area. There is an admission area with a 4 bed bay capacity and six chairs in stage 3 recovery and in the Endoscopy Unit there is a stage 1 (6 bays) and stage 2 (6 chairs) recovery /discharge area. The admission area caters for all surgical admissions to the hospital and can have up to 100 admissions a day. Main operating theatres consists of 15 operating theatres, with 23 bays in stage 1 with two 2 dedicated paediatric bays and nine stage 2 bays. General Surgical and Paediatric Ward B with 32 bed capacity. ICU consists of seven beds, average length of stay for patients being 1-2 days. · Nursing Admission through DSU MRN # 508562 · Use of Doctors Preference cards during the admission process · Measure and application of TED Stockings MRN # 508562 · Anaesthetic Nurse Check in Endoscopy Unit MRN # 439944 · Clinical Handover from Procedure room to stage 1 Recovery (Endoscopy Unit) MRN # 471064 · Time out process in the Procedure room (Endoscopy Unit) MRN # 233505 and MRN # 411626 · Intravenous cannulation MRN # 233505 and MRN # 411626 · Transfer and Clinical Handover from DSU/Admission to OT Staff MRN # 508521 · Anaesthetic Nurse Check in to Main OT MRN # 508521 · Clinical handover from OT to ICU staff MRN # 200459 · Clinical handover from Procedure Room to stage 1 Recovery MRN # 398025 · Clinical handover from Main OT to Stage 3 DSU MRN # 508567 · Discharge process MRN # 507468 · Removal of intravenous cannula MRN # 507468 · Staff Safety Huddle (Ward B) · Bedside Clinical handover from night staff to morning staff Ward B MRN # 508341; MRN # 508343; MRN # 507946 and MRN # 508449 · Group handover and bedside clinical handover in ICU MRN # 50837 and MRN # 50854 · Prepare, administer and associated documentation of a Patent Controlled Analgesia in the Recovery area MRN # 508358 · Clinical Handover from Operating Theatre to Stage 1 recovery Paediatric Patient MRN # 507733	

Requirement	Assessment Outcome	Complies
	· Clinical Handover from Operating Theatre to Stage 1 recovery MRN # 380713 · Time out process in Main Operating Theatres MRN # 380713 and MRN 507735 Non Patient processes sampled CSSD area was sampled where processes for cleaning of reusable medical devices between patients were observed during the assessment with input from the staff and Manager. Endoscope Reprocessing of endoscopes was sampled with relevant staff and Microbiological surveillance processes were sighted. A sample of medical records were reviewed to further verify documentation of processes (n=7) Observation of the patient episode enabled the assessors to verify that processes have been introduced for a number of the requirements of NSQHSS v2.1 including (but not limited to): infection prevention and control practices including transmission based precautions, hand hygiene, medication safety and administration, comprehensive care, clinical communication including patient identification and procedure matching, clinical deterioration, and emergency equipment. The Assessor spent time on both the mental health unit, neurology, paediatric and rehabilitation units to verify the following processes were in place including (but not limited to): - Emergency trolleys checks - Preventive Maintenance sticker on biomedical equipment; Fire equipment with tags and review dates - Handover using clinical communication tools at the patient bedside - Patient orientation to unit following admission (Mental Health) - Patient Care Boards in rooms outlining names of treating teams, observation category (as relevant), appointments and goals of care - Medication administration - Staffing and skill mix - Sharps and waste storage and disposal - General ward cleanliness and tidiness; spill kits - S8 and S4 medication storage and random DD Register checks. - General ward security and environmental safety (e.g. review of potential ligature points) - Patient engagement and observations levels (Mental Health) - Medication storage and documentation including medication management, high risk medications, pharmacy engagement with medication disposal, education processes for staff and patients, and reporting of medication incidents	

Requirement	Assessment Outcome	Complies
	- Medication reconciliation with the pharmacist and discharging patient - Discharge of patients and associated protocols - Refrigerator temperature monitoring - Linen storage and management - Unit Safety and Quality Boards with safety and quality data in common areas - "How are we doing?" Boards listing all of the NSQHS standards with continuous improvement strategies - Consumer engagement during handover processes and ward routine - Screening for comprehensive care. A further sample of medical records (n=8) were reviewed to further confirm documentation of processes within the healthcare record. These included, but not limited to: - Observation charts - NIMC - Medication Management Plans and Reconciliation - Medical history - Mental Health Daily Risk Assessments - Inpatient agreements – Mental Health - Mental Health Revised Clinical Risk Assessments - Psychiatric history as relevant - Multidisciplinary team meetings (Rehabilitation) - Infectious status - Risk assessments and alert sheets - Pre-screening processes - Consent processes. - Discharge processes	
Consumer Interview	During the assessment, the assessor had an opportunity to speak with a patient (MRN # 508562) following the admission process. The patient verified that they had received instructions that were clear and easy to understand prior to their admission and had been given an opportunity to ask questions throughout the patient journey. In stage 3 of the DSU recovery area the Assessor spoke with a patient on discharge post carpel tunnel surgery (MRN 507468). The patient has previously been a patient at the hospital and was highly complementary on the service and care provided to her.	Yes

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Ann Knight - National Accreditation Manager Initial and Final	Yes	Yes

Name and Designation	Opening	Closing
Matthew Tallis - General Manager Initial and Final	Yes	Yes
Justine Morrow - National Accreditation Team Initial and Final	Yes	Yes
Andriy Kurstev - DON Initial and Final	Yes	Yes
Karthik Tunki - Finance Manager	Yes	Yes
Magda Gouws - Quality Officer Initial and Final	Yes	Yes
Dana Rowe - Assessor Initial and Final	Yes	Yes
Susan Dunn - Assessor	Yes	Yes
Donna Close - Lead Assessor	Yes	Yes
Tracey Thorpe- ICU Manager Final	Yes	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	AS4187 Compliance is a large risk for the organisation. The aging infrastructure of the hospital is part of the problem. Paediatric patients from 12 months of age are noted. Workforce constraints post COVID continue to cause concern for the staff.

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO: - Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	The campus is predominantly only Brisbane Private Hospital. There is a co-located pharmacy, Slade and Lumos Radiology. BPH is a part of the Healthscope Hospital Group and receives corporate support in the form of quality management, purchasing, and human resources.
List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of: - Sterilising - Laundry services - Food preparation - Theatre Services	All contracts are managed from Corporate Head Office. Head office holds NSQHSS Accreditation in its own right with an expiry date of 27/09/2025 Linen Services Australia 31/3/2021 Medtronics Biomedical Engineering 23/8/2023

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

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Donna Close	A1011	Yes
Auditor	Dana Rowe	A1074	Yes
Auditor	Susan Dunn	A1318	Yes
Lead Auditor	Dana Rowe	A1074	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

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

Executive Summary

Brisbane Private Hospital was bought by Healthscope in 2007 following 41 years as Holy Spirit Hospital. The facility includes mental health (drug and alcohol unit), neurosurgery, rehabilitation and orthopaedics as its specialties. The 44 bed Damascus unit has been operating for over 30 years at the site.
The facility is a busy surgical hospital with 15 operating theatres. There is a high turnover through the facility. The average stay is 3-4 days. There is a 7-bed ICU with a VMO present at all times.
All open findings from the 2021 assessment have been closed with the exception of 1.31. Signage has not been updated, though it is noted that the approval for signage changes have been approved by the MAC. 1.02, 1.33, 2.11, 3.14, 5.04, 5.24 and 6.6 have been closed.

A final assessment was undertaken on 07/05/2024, with the evidence sighted the Assessor was able to close out all the Not Mets with five remaining Met with Recommendations, as although there is evidence of significant progress, the processes have not yet been fully implemented or monitored. The Assessors acknowledge the efforts of the Management team supported greatly by the Corporate team, which has resulted in the positive outcome of the final assessment.

We believe that the health service organisation has the capacity to systematically meet the requirements of the NSQHSS against the activities identified within the scope of certification. The auditor team would like to thank the health service organisation for their openness, transparency and hospitality during the review.

Several Opportunities for Improvement were identified during the assessment.

- Department Head Round Table report templates appear to be focused on financial matters, the opportunity exists to increase the focus on clinical and continuous improvement initiatives.
- The opportunity exists to document visitors to the OR (company representatives) in the patient medical record.
- The opportunity was identified to include ARTG requirements in the corporate procurement policy.
- Ensure the checklists used for high risk temperature sensitive storage (i.e. blood fridge) in the hospital are monitored for completion.

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.06	Other	Verification of clinicians and staff practicing in accordance with the Clinical Governance Framework could not be verified as a medication was administered by an anaesthetist and was not documented in the patient health care record at the time. Identification of the patient did not occur and hand hygiene was not witnessed following the procedure.	Not Met
1.07	Action not fully implemented	It appears that key staff in CSSD and endoscopy had limited operational awareness of where to locate the policy and procedure for their areas, therefore the process is not fully implemented.	Met with Recommendations
1.08	Action not monitored/reviewed	1.08 c) The process of monitoring safety and quality improvements in a timely fashion is inconsistently managed. An example is ensuring nonconforming audits are entered into the QA System and that they are actioned and closed across the organisation. The following entries were sampled: #4297 was entered on 20/6/2022 and appears to not have been actioned. #4301 entered 31/5/2022 with no further commentary available #4721 entered on 9/5/2022 with no further commentary sighted #7015 entered on 1/7/2023 with no action apparent	Met with Recommendations
1.20	Action not monitored/reviewed	There is a mandatory Training Policy and Procedure 4.10. Training is facilitated by the requirements of each staff members role. A training and competence needs analysis is available. The program include quality and safety elements as outlined in the applicable NSQHSS.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		VMO are included in the training program and are required to complete the stated requirements. Management monitor staff compliance and report to each department head to ensure non-compliance is followed up. The policy, 4.10 states managers must ensure their staff compliance is 92%. Competence must be reviewed and recorded in the staff members performance appraisal. The process of ensuring follow up of non-compliance with training at the ward level is inconsistent across wards.	
1.29	Action not fully implemented	Reporting CSSD and Endoscopy equipment failures occurs in the BGIS software, but it is not included in RiskMan. It is difficult to verify management oversight if recording does not occur in the designated system.	Met with Recommendations
1.31	Evidence is not available	This action is a technical not met as changes to signage have not yet been implemented in the facility. There was a plan to use aboriginal names, however there is a dark history in this area and the Aboriginal groups did not wish to be involved.	Not Met
2.04	Action not fully implemented	The process to approve and monitor the use of VMO consent forms utilised across the organisation is unclear.	Met with Recommendations
2.06	Action not fully implemented	Although goal setting is facilitated in the majority of clinical areas, partnering with families to set goals of care for paediatric day stay patients is not fully implemented.	Met with Recommendations
3.10	Action not fully implemented	Hand hygiene was noted to be poorly undertaken in several clinical areas despite overall compliance noted as 89%. Examples include ICU, Paediatrics, PACU and Main theatres.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
3.15	Action not fully implemented	The Credentialling process does not describe the current requirements for seeking immunisation status from VMO in accordance with the Australian Immunisation Handbook.	Met with Recommendations
3.17	Evidence is not available	Flexible endoscope microbiological testing appears on a monitoring schedule, but evidence to confirm the tests were completed routinely was not available on the days of audit AS 4187 Action Plan has not been appropriately updated and reviewed in accordance with the plans for redevelopment on the documentation supplied at audit in accordance with Advisory 18/07 V10. Failed microbiological testing is not reported into RiskMan, therefore management governance of the process is unclear.	Not Met
4.01	Other	The pharmacist was observed to write the medications of admitted surgical patients on the NIMC and the doctor signs the order the pharmacist has written. Pre-mediations are currently ordered on the anaesthetic chart not the NIMC.	Not Met
4.14	Action not fully implemented	Monitoring of fridges which hold temperature sensitive medications are inconsistently managed across departments. An unlabelled open Insulin NovoRapid Pen was present in rehabilitation.	Met with Recommendations
5.02	Action not fully implemented	Assessors were unable to verify the consistent monitoring and review of comprehensive care plans in the Damascus wards.	Met with Recommendations
5.05	Evidence is not available	Following the review of a sample of inpatient Health Care Records and discussions with staff,	Not Met

Action	Gaps in implementation identified	Recommendation(s)	Rating
		inconsistent application of the Multidisciplinary Team clinical reviews for Damascus was identified.	
5.13	Action not fully implemented	Goals of care in paediatrics are sought and documented in overnight admissions, however partnering with families to set goals for day stay paediatrics in not fully implemented.	Met with Recommendations
5.14	Action not fully implemented	Goals of care in paediatrics are sought and documented in overnight admissions, however partnering with families to set goals for day stay paediatrics in not fully implemented.	Met with Recommendations
5.30	Action not fully implemented	Cognitive risk assessments in day surgery patients are only completed if patients over 65 years have other co-morbidity as noted in HMR6.13G. This is not in keeping with the advice in the Delirium Clinical Care Standard, therefore the process is not fully implemented.	Met with Recommendations
6.05	Other	Assessors could not consistently verify anaesthetist participation in patient identification procedures during all episodes of care, examples included medication administration and handover to PACU. Noted there was participation in the time out processes sampled. It is also noted that QML only use two identifiers for patients in the blood register.	Not Met
6.08	Action not fully implemented	Communicating the goals of care in day stay paediatrics during transitions of care is not fully implemented.	Met with Recommendations
8.02	Other	Paediatric trolley was located in the storeroom obstructed by drip poles and equipment. There were lists for children in progress on the day of assessment.	Not Met

Action	Gaps in implementation identified	Recommendation(s)	Rating
		No medications are located on the paediatric emergency trolly in PACU and does not have a tamper proof seal insitu. The assessor was unable to verify the monthly checks performed on the Paediatric Trolley emergency medications. The resus trolley for endoscopy and DSU is located in the endoscopy suite but is only checked on the days endoscopy is working.	
8.04	Action not fully implemented	Trending of the observations recorded on the Observation and Response Charts is inconsistently completed across multiple areas of the hospital.	Met with Recommendations

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.20	Action not fully implemented	Evidence sighted at the final assessment that management have applied a targeted approach with communication to all VMOs regarding education requirements. Risk assessing process are in place, targeting VMOs with no public appointments, high admission rates and scope of practice. A register of all VMO training has been implemented, however as this process is in its infancy and not yet fully implemented, a Met with Recommendations rating with remain.	Met with Recommendations
1.31	Other	Evidence sighted at the final assessment that all primary actions have been undertaken to change the naming conventions which include CAPEX approval, discussion at MAC, correspondence to VMO's and tenants, quotes obtained to update Fire evacuation diagrams to reflect hospital renaming of levels, quote for purchase and installation of new lift buttons, quote obtained and approved for new lift/direction signage, consumer involved with planning and will continue to be involved in the implementation process. Implementation to occur 07/2024.	Met with Recommendations
2.04	Action not fully implemented	Evidence sighted at the final assessment management are currently in the process of ensuring that all consents (including VMOs own consent forms) are in line with the Healthscope Consent to Medical / Surgical Treatment policy 2.17. Consent form discussion added to Medical Advisory Committee Agenda 15/05/2024. This process is yet to be fully implemented.	Met with Recommendations
3.15	Action not fully implemented	Evidence sighted at the final assessment that management has communicated to all VMOs of	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		the requirement to provide proof of immunisation status to vaccine preventable diseases as well as COVID. The VMO training register with immunisation status is in place. As this process is in its infancy and not yet fully implemented a Met with Recommendations rating with remain.	
5.14	Action not fully implemented	Evidence sighted at the final assessment that the HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor on paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in Round Table meetings. Medical record review and discussion with staff verified that processes are in place to identify goals for day stay paediatrics patient, however the evaluation of this process is not fully implemented.	Met with Recommendations

DETAILED REPORT FOR STANDARDS ASSESSED

Action 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance
Evidence Reviewed
A culture of safety and quality improvement exists within the organisation. Consumers and their carers are engaged in the process of reviewing safety and quality data. The highest level of governance in the organisation is the Healthscope Board. The National Accreditation Manager described the process to imbed quality in the business. There is a new strategy to increase the role of the NUMS in the quality system. It is hoped this will increase ownership. There is a newsletter publication sent quarterly by the Accreditation Manager named Accreditation Matters. The primary goal of this publication is shared learning on the findings raised at accreditation assessments. HONOS and AROC reporting is used to monitor the performance of rehabilitation and mental health wards. ACHS indicators are used for general wards, theatres and endoscopy.
Rating
Met
Findings
-

Action 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Evidence Reviewed
The Healthscope Reconciliation Action Plan dated January 2024-December 2025 has been endorsed by the Healthscope CEO and the CEO of Reconciliation Australia. Healthscope undertakes to close the gap in healthcare outcomes and well-being indictors for Aboriginal and Torres Strait Islander peoples by 2033. The plan covers the Healthscope vision, timeline, steering committee members, relationship, opportunities, respect and governance of the process. A person who identifies as Aboriginal or Torres Strait Islander sits on the Consumer committee. The gentleman came to the facility to discuss his input into the RAP.
Rating
Met
Findings
-

Action 1.03
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
Evidence Reviewed
Healthscope Brisbane Private Hospital has defined a Clinical Governance Plan dated 03/2023 - 03/2024. This document is a consumer approved publication. The plan references the Australian Commission for Safety and Quality in Healthcare National Model of Clinical Governance. The clinical governance framework supports a One Healthscope 2025 initiative across all aspects of the strategy. The Frameworks focus on delivering safe and effective patient centred care underpinned by the following eight key pillars. -Leadership and Culture -People and Partnerships -Clinical Data and Outcomes -Managing Risk -Quality improvement -Staff Capability Building -Evidence Based Practice -Patient Experience

Rating
Met
Findings
-

Action 1.04
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
Evidence Reviewed
The Healthscope Reconciliation Action Plan dated January 2024-December 2025 has been endorsed by the Healthscope CEO and the CEO of Reconciliation Australia. Healthscope undertakes to close the gap in healthcare outcomes and well-being indictors for Aboriginal and Torres Strait Islander peoples by 2033. The plan covers the Healthscope vision, timeline, steering committee members, relationship, opportunities, respect and governance of the process.
Rating
Met
Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
The HSO uses it clinical governance framework to ensure organisation-wide awareness of safety and quality data. The following elements were verified during the assessment. State Licencing Clinical Indicator Reporting and Benchmarking Patient Satisfaction Survey Risk register and Risk Management System

Credentialing and scope of practice process for all VMO's

Nurses and VMO's registration with AHPRA is monitored by the Executive office.

Rating

Met

Findings

-

Action 1.06

Clinical leaders support clinicians to:

a. Understand and perform their delegated safety and quality roles and responsibilities

b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Evidence Reviewed

Initial Assessment: Clinicians are provided with position/job descriptions. Each contains a reference to the safety and quality systems in the organisation.

Medication was administered by an anaesthetist and not documented in the patient health care record. This reflects a lack of understanding of their quality and safety roles and responsibilities. A not met finding has been awarded.

Final Assessment: Evidence sighted at the final assessment that Management initially held a meeting with the Executive team, Quality team, Departmental NUM's to discuss the findings on 19/02/2024. Discussions were undertaken at the Anaesthetic CRAFT group with minutes sighted 26th March 2024, followed by an email from the DON to all Anaesthetists and Intensivist regarding findings, dated 09/04/2024. Communication to the Anaesthetist via letter dated 27/02/2024 regarding expectations for compliance with medication, documentation, ID checking, Hand Hygiene and ANTT. The VMO was requested to complete HH, Aseptic Technique and Medication Safety Standard training with evidence sighted of completion with a signed declaration 10/03/24.

Education provided to Nursing staff about challenging unsafe practice by VMOs and "Speak up for Safety" - ICU Monthly catch up sighted dated 03/24 and D floor ward meeting 06/03/2024.

Restricted access to medication rooms for VMO's to facilitate changes in practice.

Rating

Met

Findings

-

Action 1.07
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Evidence Reviewed
Initial Assessment: Policies and procedures are in place to support ongoing review and maintenance of the information available to staff. The reviews are in response to updated clinical care standards, changes in regulation or the scope of service of the facility. Legislation and regulatory instruments are included in the policy suite at the corporate level. Healthscope Policy: 1.14 Document Control 1.01 Policy Review Authorisation 1.10 Policy Compliance Monitoring HINT intranet holds the policy, procedure and forms for the Hospitals, in addition local policies are in place for Brisbane Private. It appears that key staff in CSSD and endoscopy had limited operational awareness of where to locate the policy and procedure for their areas, therefore the process is not fully implemented. Final Assessment: Verified at the final assessment via discussions with staff that both CSSD and Endoscopy areas have access to corporate, local site and HICMR policies with links available on all computers to assist staff in finding policies.
Rating
Met
Findings
-

Action 1.08
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Evidence Reviewed
Initial Assessment: RiskMan has an eQuaMS module that facilitates internal audit and system improvements. Inputs to the improvement process, Quality Action Plans include but are not limited to the incident management and reporting system, internal audit program, patient, staff and doctor feedback and clinical indicator reporting. The department heads are responsible for implementing the quality action plans. The Consumer Focus Group are involved in reviewing and suggesting quality actions also. The Quality Action Plan Summary was sampled as follows: #3988 AS4187 compliance #4304 Not meeting patient satisfaction target of 88.9% #6037 Audit result 16% did not have IV line labelled in ICU and 55% in the wrong position. #7569 Blood audit not up to standard. 1.08 c) The process of monitoring safety and quality improvements in a timely fashion is inconsistently managed. An example is ensuring nonconforming audits are entered into the QA System and that they are actioned and closed across the organisation. The following entries were sampled: #4297 was entered on 20/6/2022 and appears to not have been actioned. #4301 entered 31/5/2022 with no further commentary available #4721 entered on 9/5/2022 with no further commentary sighted #7015 entered on 1/7/2023 with no action apparent Final Assessment: Evidence sighted at the final assessment that all NUMS were provided with education on eQuaMS which was provided by the National Accreditation Manager. A review of all actions plans were undertaken with consolidation of action plan as appropriate. eQuaMS are discussed during manager's round tables identifying action plans and progress with actions. Processes will continue to be monitored through the meeting structure.
Rating
Met
Findings
-

Action 1.09
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce

c. Consumers and the local community
d. Other relevant health service organisations

Evidence Reviewed

Reports are provided to the governing body via the committee structure at regular intervals. The Governing body is noted as the Healthscope Board, however locally, there is an Executive Leadership Committee and a Medical Advisory Committee. The workforce are provided with reports via the Quality Boards, Huddles, Round Tables and Staff Meetings. The Consumer Representatives sit on the Consumer Focus Group and the Quality Committee.

Rating

Met

Findings

-

Action 1.10

The health service organisation:
a. Identifies and documents organisational risks
b. Uses clinical and other data collections to support risk assessments
c. Acts to reduce risks
d. Regularly reviews and acts to improve the effectiveness of the risk management system
e. Reports on risks to the workforce and consumers
f. Plans for, and manages, internal and external emergencies and disasters

Evidence Reviewed

The Risk Register is held in the RiskMan software program. This was sampled on site. The Risk Assessment has 126 discrete records, a sample includes
#7554 Child Security
#7559 Scope Management
#7565 Retained instruments
#7596 Medical Record Storage and Disposal
#7599 Suicide and Self Harm
#7603 Absconding Patient
#7607 Failure to Identify Patients

#7612 Medication Error
#7618 Deteriorating Patient
#7631 Suspected Child Abuse
#7649 Medical Record Documentation including comprehensive Care, Risk Assessments and Care Variances
#7652 Adverse Drug Reaction
#7674 Consent to Medication Treatment
#13587 Incident Management
#16808 & #16809 Blood Transfusion
#17133 Privacy and Confidentiality
Legislation is reviewed at the level of the corporate legal team. A recent example was the institution of the Qld Voluntary Assisted Dying Legislation.

Rating

Met

Findings

-

Action 1.11

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

Evidence Reviewed

The Healthscope Incident Management Policy 2.13 10/2023 provides guidance on how to conduct the processes surrounding untoward events. These included near misses, incident identification, notification, management and analysis of these events.
The Consumer Representatives both described their role in providing feedback to the management team with following their review of incidents.
Risk Man was sampled:

#2110370 28/11/2023 TGA Product recall
#2117167 24/1/2024 Privacy Breach
#2072900 29/3/2023 incorrect side shoulder block - Open Disclosure conducted
#2097925 8/9/2023 Tapentodol given instead of Endone
#2081798 26/5/2023 Heparin given one day early
#2096346 30/8/2023 Discectomy had a cardiac event - Coroners case.
#2064320 1/2/2023 Anaphylaxis
#2066624 16/2/2023 4 year old with a blood post tonsillectomy.
RiskMan software has a journaling function which allows the actions and investigations to be documented.

The Round Table from DSU from November 2023 noted 4 incidents per 499 bed days and in endoscopy, 2 incidents per 193 bed days.
Executive Leadership Minutes from 23/1/2024, 7/11/2023 and 21/11/2023 noted the review of incidents.

Rating

Met

Findings

-

Action 1.12

The health service organisation:
a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework
b. Monitors and acts to improve the effectiveness of open disclosure processes

Evidence Reviewed

The Organisation has an Open Disclosure Policy 2.30 10/2023 references the Australian Open Disclosure Framework. The Incident Management Policy 2.13 is referenced. Documentation in the RiskMan software is required.
Staff training on Open Disclosure is currently noted to be 98.6% across the hospital.

Rating

Met

Findings
-

Action 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
Evidence Reviewed
There are QR Codes in the elevators and on display throughout the facility that allow patients and visitors to provide feedback. Net Promoter scores are assigned. These levels are monitored at all levels of the organisation. In many hospitals, food and parking. Qualtrics surveys are undertaken. The facility has Quality Boards in each Department. The one on the Damascus level for January published a satisfaction rate of 83%. In the kitchen the Quality Board noted a 44% patient rating. Each Board is scoped to the area. Published questions are subtly different. Medical Advisory Committee Minutes from 12/12/2023 discussed the NPS and how managing complaints regarding the food would assist in lifting the score.
Rating
Met
Findings
-

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

Evidence Reviewed
Complaints are received via several means. At Brisbane Private Hospital, there are very active Consumer representatives. During the assessment both gave up their time to discuss their roles with the assessment team. The two representatives attend the Quality Management and Consumer Focus Meetings. A large part of their roles is reviewing feedback. They also make themselves available to visit and interact with patients in their rooms. They elicit very honest feedback and provide it to management for consideration. Complaints management processes are described as robust and are managed by the manager involved. Formal complaints logged in the RiskMan software program. All complaints reported through the Committee structure. A selection of complaints were sampled on site: #69689 20/2/23 Multiple issues noted with ward and staff, all resolved to the satisfaction of the patient. #70643 20/4/2023 Multiple issues noted, the complaint was unresolved as the patient refused to accept an apology #71980 7/2/2023 Apology was documented and the complaint noted as resolved #71980 a needlestick intraoperatively, the doctor documented the open disclosure, however the patient did not remember. #74107 29/12/2023 Complaint noted, investigated and resolved. Example's of how complaints are managed include the Round Table process. The Report from 10/2023 from ICU noted feedback.
Rating
Met
Findings
-

Action 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher- risk groups into the planning and delivery of care
Evidence Reviewed
The facilities utilises information from their patient information software system, WebPAS to identify the diversity of its consumers. Interpreters are used when necessary and at times the use of family members for interpreting was raised by staff during interviews with assessors. If an interpreter is used to gain informed consent, they must sign the consent form to verify the translation.

The Report was run on the day of assessment, it was noted that the majority of clients are English speaking. AS of 14/2/2024, Afrikaans is 39/26140 admissions and Mandarin is 44/26140.

Rating

Met

Findings

-

Action 1.16

The health service organisation has healthcare record systems that:

a. Make the healthcare record available to clinicians at the point of care

b. Support the workforce to maintain accurate and complete healthcare records

c. Comply with security and privacy regulations

d. Support systematic audit of clinical information

e. Integrate multiple information systems, where they are used

Evidence Reviewed

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

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

Internal Medical Record Audits are conducted via the MARS Audit system.

Rating

Met

Findings

-

Action 1.17

The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:

a. Are designed to optimise the safety and quality of health care for patients

b. Use national patient and provider identifiers

c. Use standard national terminologies

Evidence Reviewed

My Health Record System Policy and Procedure 2.66 provides advice on consenting for MHR, Admission Notifications, Nursing Discharge Summaries, Training, Accessing the MHR system, Security, Data Breaches (initial reporting, responses & further steps), Queries and Review.

Healthscope Policy:

1.14 Document Control

1.01 Policy Review Authorisation

1.10 Policy Compliance Monitoring

Rating

Met

Findings

-

Action 1.18

The health service organisation providing clinical information into the My Health Record system has processes that:

a. Describe access to the system by the workforce, to comply with legislative requirements

b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Evidence Reviewed

My Health Record is currently in use by the facility. Accuracy is internally audited. The Healthscope Nursing Discharge Summary Report for BPH 462 discharges, 441 were finalised as at 31/1/2024, overnight 714 and finalised 634. KPI >85%. Both within range.

Rating

Met

Findings

-

Action 1.19
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
Evidence Reviewed
The Governing body has approved the following orientation program to ensure role and responsibilities of staff are communicated. Orientation is conducted prior to staff commencing duty. On the day of assessment, 30 new staff were attending orientation. Each manager keeps records of their new staff. The Consumer Representatives are included in the orientation program. VMO are sent information as a component of the credentialing process.
Rating
Met
Findings
-

Action 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
Evidence Reviewed
Initial Assessment: There is a mandatory Training Policy and Procedure 4.10. Training is facilitated by the requirements of each staff members role. A training and competence needs analysis is available. The program include quality and safety elements as outlined in the applicable NSQHSS. VMOs are included in the training program and are required to complete the stated requirements. Several Dashboards are in use across the facility. While the Assessment team notes a transition between two different platforms, it was difficult to know what the overall compliance rates were for staff. Therefore the process of ensuring follow up of non-compliance with training at the ward level is inconsistent across wards.

Compliance for Manual handling was 86%, Bloodsafe 69.6%, Cultural Competency 76.9%, Hand Hygiene 93.7%, WAVE Violence training 68.3%, P2 Masks 72.1%, VAD 87% and Open Disclosure 98.6%. These examples were compared to Orderlies which were 28.6% overall compliance with education, Food services 76% and Ecolab Chemical handling 57.8%. The Housekeeping Roundtable Report said 86% compliant.

Final Assessment: Evidence sighted at the final assessment that management have applied a targeted approach with communication to all VMOs regarding education requirements. Risk assessing processes are in place, targeting VMOs with no public appointments, high admission rates and scope of practice. A register of all VMO training has been implemented, however as this process is in its infancy and not yet fully implemented, a Met with Recommendations rating with remain.

The processes of ensuring follow up of non-compliance with training is consistent across the organisation has now been implemented, these processes include all managers reporting compliance rates through monthly Manager Round Table Meeting with reporting on non-compliance strategies included. Managers addressing mandatory training expectations to be reinforced at SLT meetings.

Rating

Met with Recommendations

Findings

Evidence sighted at the final assessment that management have applied a targeted approach with communication to all VMOs regarding education requirements. Risk assessing process are in place, targeting VMOs with no public appointments, high admission rates and scope of practice. A register of all VMO training has been implemented, however as this process is in its infancy and not yet fully implemented, a Met with Recommendations rating with remain.

Action 1.21

The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

Evidence Reviewed

Staff are required to complete education on ATSI clients in order to demonstrate cultural competence. The current compliance rate for the hospital is sitting at 76.9% as noted on the Dash platform. The hospital intranet also has ATSI resources for the staff to reference as necessary.

Rating

Met

Findings

-

Action 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Evidence Reviewed
Performance Reviews (Appraisals) are reported as a compliance task in the Round Tables monitoring DSU Round Table was sighted from November 2023 which noted which appraisals were due for actioning. Training needs are identified and documented in the Performance Review document, HSPHDoc20019.
Rating
Met
Findings
-

Action 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Evidence Reviewed
Scope of practice is defined as a component of credentialing. The facility is required to document what qualifications are required for each role. Four credentialing letters were sighted as an output of the CGOV software program. It appears that the scope of practice requested is then reviewed and added to the approval letter. Paediatric rights were noted on the anaesthetist's credentialing letter dated 23/01/2024.
Rating
Met

Findings
-

Action 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Evidence Reviewed
There is a formal credentialing process for clinicians designed to reflect their scope of practice. AHPRA registration is monitored automatically via CGOV. The Credentialing User Guide V4 December 2019 is the current document used to assist in the credentialing process. Applicants are required to submit a CV, the names of two referees (preferably one from a current BPH VMO), AHPRA and Insurance. Credentialing of medical officers is described in the Bylaws/Facility Rules. The Medical Advisory Committee (MAC) review and approve all new visiting medical officers. Scope of practice is defined in the approval letters sent following MAC approval. Credentialing is completed every 3 years for allied health and surgical assistants. VMO are credentialed for five years. A review of VMO files was undertaken during the assessment current GESA Certification was not on file for two of the four endoscopists reviewed, Drs Shahza and Wong. This was supplied after the assessment. The Credentialing process does not describe the current requirements for seeking immunisation status in accordance with the Australian Immunisation Handbook or what mandatory training is required for VMO. No immunisation records were present for three of the four files sampled. Only one of the files contained any training records. That was the college triennium for an anaesthetist. Please refer to the finding in 3.15. The effectiveness of the credentialing process is monitored by the General Manager.
Rating
Met
Findings
-

Action 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality

b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Evidence Reviewed

Agency staff are orientated to the facility prior to commencing the shift. An Information Pack is provided which covers confidentiality, dress code, ID badges, security, contact details, visitors, maintenance, safety and quality, preventing and controlling health care associated infections, medication safety, patient identification, clinical handover, recognising and responding, rapid response system, falls, pressure, documentation, workplace discrimination and harassment, WH&S, incident reporting, hazard reporting, safe manual handling, safe materials, emergency codes, skills assessments and tour of department.

Records sighted for NG 15/3/22, SC 9/3/23 and SK periop 12/12/23.

Rating

Met

Findings

-

Action 1.26

The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate

Evidence Reviewed

Supervision is provided in the facility by appropriately qualified management staff. After hours there are supervisors in the facility/available. There is an intensivist on duty during the day and a RMO 24 hours per day. The ICU staff respond to the MET Calls.

Rating

Met

Findings

-

Action 1.27

The health service organisation has processes that:

a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice

b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Evidence Reviewed

Sufficient tools and information is available to clinicians at the point of care. Tools include but are not limited to

Clinical Care Standards

Injectable Handbooks (AIDH)

Therapeutic Guidelines Online eTG Complete

MIMS on line are available on all computer desktops

There are clinical pathways linked to the care needs identified in the comprehensive assessment process at pre-admission or admission. An example on the orthopaedic ward was provided, when during handover the RN reinforce the urosepsis pathway of care to the oncoming nurses for a patient.

Rating

Met

Findings

-

Action 1.28

The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes

b. Provide feedback to clinicians on variation in practice and health outcomes

c. Review performance against external measures

d. Support clinicians to take part in clinical review of their practice

e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems

f. Record the risks identified from unwarranted clinical variation in the risk management system

Evidence Reviewed

Variation in practice is monitored through the organisation submitting their outcomes to the ACHS clinical indicator data set. Data from these bodies enables feedback to clinicians and benchmarking activity. Data is reconciled with the incident and complaint management systems to ensure any individual variation is identified and discussed at each craft group Mortality and Morbidity Meeting, then reported to the MAC.

The facility collects two additional colonoscopy indicators.

Variation in practice was discussed with both a MAC member and the GM of the facility.

Minutes of the Neuro Craft Group MM from November 2023 demonstrated review of 53 RiskMan incidents, a review to assess if any doctor related incidents occurred.

Nurse Unit Managers hold Round table Meetings to monitor and discuss quality and safety Data. An example from the DSU from 11/2023 was reported with internal audits, appraisal monitoring, complaints, and incidents discussed.

Rating

Met

Findings

-

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment

b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Evidence Reviewed

Initial Assessment: The facility has a preventive maintenance program. All biomedical equipment and Body protection areas contained compliance plates sighted during the assessment were noted to be in date. Sampling of records include TMV, monthly temperature testing , legionella testing, Theatre air conditioning (HEPA and air changes) and backflow reports were sampled. Processes are in place to ensure that infrastructure is fit for purpose.

There is also a reactive maintenance process for staff to quickly respond to breakages in order to minimise patient risk.

The Water Management Plan for the facility was sighted.

Maintenance is managed by an external contractor BGIS. There is a weekly report sent to the Finance Manager that includes incidents, and hazards from the last week, permits and licences, preventive and reactive maintenance are noted. The report from 12/02/2024 included:

• Air-conditioning AHU 4.3 on level 4 is at end of life and needs be refurbished. AWAR submitted includes a new shaft.

• Brendan continues to make good progress on patient chart baskets installation.

• Learnings gleaned from the sterile stock loss & discussed at a RCP chaired forum. Air pressure issue still to be resolved with builder. Compressor # 4 due for installation 10th & 11th February.

• Emergency lighting batteries (9 x 32kgs) installed this week on level 3 of the Specialist Centre.

• Discussions with Fireboard & BGIS regarding floor level changes.

• Quarterly potable water Legionella tests ordered.

• Monthly steam boiler service due Monday 5th February

• VAE air-conditioning commissioned to provide proposals for air-conditioning in DSU (x2), theatre office & lift motor room.

Reporting CSSD and Endoscopy equipment failures occurs in the BGIS software, but it is not included in RiskMan. It is difficult to verify management oversight if recording does not occur in the designated system.

Final Assessment: Evidence sighted at the final assessment that equipment failures to Endoscopy/CSSD /Perioperative area added to IPC committees agendas to monitor and identify issues and reporting in RiskMan occurring. Discussion with the CSSD manager confirmed this process. SDSs sighted in the CSSD and Endoscopy area were noted to be within the required expiry dates.

Rating

Met

Findings

-

Action 1.30

The health service organisation:

a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce

b. Provides access to a calm and quiet environment when it is clinically required

Evidence Reviewed

There are documented policies for aggression management. Occupational Violence and Aggression - Incident Management 6.15a, Occupational Violence and Aggression OVA Management Principles and Prevention 6.15

Emergency Plans and internal phone directories are available for staff.

Emergency flip charts where sighted in appropriate locations with staff confirming when they would be used.

Emergency and Safety Procedures which informs patients about taking direction from staff in the event of a fire or smoke alarm activation are included in the Fire training.

WAVE Training is conducted with staff, this has a compliance rate currently of 68.3%.

Nurse call pendants are available in all areas.

There is restricted entry into the hospital after hours.

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

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

Rating
Met
Findings
-

Action 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Evidence Reviewed
Initial Assessment: This action is a technical not met as changes to signage have not yet been implemented in the facility. Initial plans were in place to utilise aboriginal names, however the Aboriginal groups did not wish to be involved. Final Assessment: Evidence sighted at the final assessment that all primary actions have been undertaken to change the naming conventions which include CAPEX approval, discussion at MAC, correspondence to VMO's and tenants, quotes obtained to update Fire evacuation diagrams to reflect hospital renaming of levels, quote for purchase and installation of new lift buttons, quote obtained and approved for new lift/direction signage, consumer involved with planning and will continue to be involved in the implementation process. Implementation to occur 07/2024.
Rating
Met with Recommendations
Findings
Evidence sighted at the final assessment that all primary actions have been undertaken to change the naming conventions which include CAPEX approval, discussion at MAC, correspondence to VMO's and tenants, quotes obtained to update Fire evacuation diagrams to reflect hospital renaming of levels, quote for purchase and installation of new lift buttons, quote obtained and approved for new lift/direction signage, consumer involved with planning and will continue to be involved in the implementation process. Implementation to occur 07/2024.

Action 1.32
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
Evidence Reviewed
Discussions with management and staff confirmed that the HSO has flexible visiting arrangements to meet patients needs with overnight stays permitted if clinically indicated. Examples provided include social support, if the patient is a minor, during end of life care or for parents of newborns. The Patient Information Guide has information about visiting arrangements.
Rating
Met
Findings
-

Action 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Evidence Reviewed
The Governing Body has approved the strategic plan for ATSI clients. Acknowledgment of Country is conducted before meetings. Cultural Diversity, Sensitivity and Responsiveness Policy informs staff how to deal with the needs of Aboriginal and Torres Strait Islander (ATSI) patients and their carers and families, in addition to the evidence provided demonstrated local community input about the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. The environment has been adjusted to welcome ASTI people in the following manner: Flags are on display in the entry and ward reception desks
Rating
Met
Findings
-

Action 2.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers
Evidence Reviewed
During the assessment, BPH organised for two of their Consumer Representatives to meet with the assessment team. Both discussed their work in the facility. Consumer #1 has been active in the hospital since October 2023. Not only does she review a range of safety and quality data and provide feedback regarding the data, she visits patients in their rooms to seek their opinions and suggestions for improvement. A range of suggestions have been provide thus far, however all that are confirmed with the entrance to the facility are governed by the Brisbane City Council and take time. Both Representatives described their Orientation Process in the hospital. The facility has a consumer Committee Terms of reference to guide the efforts of the members.
Rating
Met
Findings
-

Action 2.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers
Evidence Reviewed
The Clinical Governance Framework outlines the organisation's processes for monitoring partnering with consumers. This mandates the consumer engagement processes for the hospital and how the outputs are reported to the highest level of governance and how improvement strategies are identified and implemented. Staff describe the processes for reporting via the Quality Boards and staff meetings The Consumer Representatives confirmed their attendance at the consumer Focus Group and the Quality Committee Meetings.

Rating
Met
Findings
-

Action 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers
Evidence Reviewed
Australian Charter of Healthcare Rights (ACHCR) is in use and on display throughout the facility. The facility ensures patients read and understand the Australian Charter of Healthcare Rights and Privacy Policy at pre-admission/admission or on arrival.
Rating
Met
Findings
-

Action 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Evidence Reviewed
Initial Assessment: There is a documented policy which addresses informed consent. The Financial Consent form HMR4.8 meets the requirements of advisory 18/10. Procedural consents were present in the files sampled across the clinical areas. VMOs use their own consent forms for their admissions into Brisbane Private Hospital. The process to approve and monitor the use of VMO consent forms utilised across the organisation is unclear. Consenting is monitored via the internal audit schedule. An example is the consent audit performed as a component of the clinical pathway which was 83% compliant. Final Assessment:

Evidence was sighted at the final assessment that management are currently in the process of ensuring that all consents (including VMOs own consent forms) are in line with the Healthscope Consent to Medical / Surgical Treatment policy 2.17. Consent form discussion was added to Medical Advisory Committee Agenda 15/05/2024. This process is yet to be fully implemented.
Rating
Met with Recommendations
Findings
Evidence sighted at the final assessment management are currently in the process of ensuring that all consents (including VMOs own consent forms) are in line with the Healthscope Consent to Medical / Surgical Treatment policy 2.17. Consent form discussion added to Medical Advisory Committee Agenda 15/05/2024. This process is yet to be fully implemented.

Action 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Evidence Reviewed
There is a documented policy which addresses the capacity of patients to consent to treatment and to involve a substitute decision maker. Staff have access to interpreter service as required. The presence of an advance care directive is documented on the alert sheet.
Rating
Met
Findings
-

Action 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Evidence Reviewed
Initial Assessment: Staff are supplied with information on how to identify Goals of Care. There is a SOP for identifying Goals of Care.

White Boards are available in the majority of patient rooms. Goals of Care are very individual to the clinical service provision.

Clinical Handover was witnessed in several clinical areas to confirm that clinicians partner with their patients to plan, communicate and make decisions about care.

Although goal setting is facilitated in the majority of clinical areas, partnering with families to set goals of care for paediatric day stay patients is not fully implemented.

Final Assessment: Evidence sighted at the final assessment that the HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor regarding paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in the Round Table meetings.

Medical record review and discussion with staff verified that processes are in place and continue to be monitored through the auditing schedule.

Rating

Met

Findings

-

Action 2.07

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Evidence Reviewed

Patient centred care is described in the Healthscope policy suite.

Staff describe the use of a structured handover tool, ISBAR.

Patients interviewed during the assessment confirmed the clinical handover policies include the patient and their family. Goals of care or 'What matters to me today" are identified and communicated.

Assessors observed full engagement of patients and family with appropriate information being disseminated to patients during the bedside handover. This shared decision making for ongoing care is documented in the comprehensive care plan. Huddles are performed prior to the bedside handover in the wards. This was witnessed in Damascus, B floor and D floor.

Rating

Met

Findings

-

Action 2.08
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
Evidence Reviewed
The diversity of the population is mainly English speaking and relatively homogenous. The Australian Charter of Healthcare rights (ACHCR) is available in a number of different languages to patients and is monitored through the various bedside audits completed at departmental levels. The ACHCR is displayed in patient waiting areas, in the patient Compendium located in each patient room and also on the website.
Rating
Met
Findings
-

Action 2.09
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
Evidence Reviewed
Local consumers are engaged in the review of patient information. Corporate policies on consumer participation include how information is reviewed by consumers, families and their carers. The Hospital compendium is available in hard copy/soft copy. Examples provided included the Reconciliation Action Plan (local) and the Escalation of Care Brochure devised for families and patients.
Rating
Met
Findings
-

Action 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge
Evidence Reviewed
Clinical areas were accessed by the assessment team to ensure the organisation supports their staff to communicate with consumers regarding their health care. If necessary, staff will arrange for an interpreter to ensure that communication with a patient is meaningful. The patient information booklet has been prepared to provide patients with information about the hospital's services with the booklet prepared with consumer input. Staff describe the following policies and processes. Communicating for safety Handover Communication Boards Diversity of consumers Discharge advice (including My Health Record integration Clinical handover was witnessed during transitions of care which adhered to the stated policies.
Rating
Met
Findings
-

Action 2.11
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
Evidence Reviewed
Consumer engagement occurs in two ways. Firstly, via patient centred care at the clinical interface.

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

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

The diversity of consumers is assessment regularly by the quality team. The facility is patronised by mainly English speakers. The Report run on the day of assessment, found that Afrikaans speakers comprised 39 of the 26140 admissions and Mandarin is 44 of the 26140 admissions.

Rating

Met

Findings

-

Action 2.12

The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Evidence Reviewed

There is a Consumer engagement policy in place which includes a structured orientation for Consumers Representatives. An orientation to the hospital, and information on the NSQHSS is included.

During the assessment the Assessor has an opportunity to meet with the Consumers Representatives who confirmed orientation and confidentiality requirements.

Quality Boards have been installed in each department to display feedback and performance data to both patients and staff.

The Consumer focus Group Meetings were held on the 7/2/24 and 1/11/2023 and the Quality Committee Meetings were attended by Consumer s on 28/11/2023 and 26/9/2023. Minutes verify the processes and attended.

Rating

Met

Findings

-

Action 2.13

The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Evidence Reviewed
The governing Body of Healthscope has approved the strategic plan for ATSI clients. Acknowledgment of Country is conducted prior to meetings throughout the facility. Cultural Diversity, Sensitivity and Responsiveness Policies inform staff of how to deal with the needs of Aboriginal and Torres Strait Islander (ATSI) patients and their carers and families. In addition to the evidence provided, the local community First Nations Representative discussed the cultural beliefs and practices of Aboriginal and Torres Strait Islander people in the facility with the audit team.
Rating
Met
Findings
-

Action 2.14
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce
Evidence Reviewed
Quality Improvements resulting from patients feedback are incorporated into the clinical framework of the facility, this is reported to the Executive Leadership, MAC and Quality committees. During the assessment the Assessors had an opportunity to meet with two Consumers Representatives who confirmed how their advice and feedback had been incorporated into training for the workforce. Quality Boards have been installed in each department to display feedback and performance data to both patients and staff.
Rating
Met
Findings
-

Action 3.01
The workforce uses the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for infection prevention and control

b. Identifying and managing risks associated with infections

c. Implementing policies and procedures for antimicrobial stewardship

d Identifying and managing antimicrobial stewardship risks

Evidence Reviewed

Governance of the Infection Prevention and Control standard is provided through the Infection Control Committee (ICC) and the Antimicrobial Stewardship (AMS) Committee which has an extensive membership including Infectious Disease Physician, Infection Control Coordinator, Microbiologist (Pathology Company), Clinical area NUMS and the Educator. There are documented terms of reference. Infection Control Committee TOR 12/22 and AMS TOR 12/2019.

Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023 and AMS minutes dated 7/12/2023.

Brisbane Private Hospital utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR) to ensure practices are congruent with ACORN, and other relevant infection control standards which consists of a second yearly onsite review with the last review 2022. The review is primarily focused on the high risk areas with an action plan developed with documented actions/outcomes.

Risks associated with infections antimicrobial stewardship risks are managed through the risk register with regular reviews conducted to ensure appropriateness.

Risk 7541 Gastroenteritis Outbreak-inadequate preventing and management

Risk 7559 Scope Management -inadequate management

Risk 7560 Loan Equipment -inadequate management

Risk 7561 Cannulated instruments -inadequate processing

Risk 7641 Sterilisation Failure -inadequate prevention and management

Risk 7679 Notifiable Disease -

Risk 16810 Sterilisation Service

Risk 17077 Aseptic Technique

Risk 17078 Environmental Cleaning

Risk 17079 Invasive devices

Risk 17082 Endoscopy instrument flow

Risk 18218 VMO Aseptic technique -training credentialed medical practitioners

Risk 19219 Antimicrobial Stewardship

Risk 19583 Safety of Patients on Transmission named precautions

Risk 19269 CSSD equipment failures

Risk 19694 Water and Air Management

Policies sighted

18.53 Antimicrobial Prescribing and Management 07/2021
8.38 Aseptic Technique 04/2022
8.10 Hand Hygiene 07/2023
15.05 Immunisations for Vaccine Preventable Diseases for Healthcare Workers 02/2022
12.06 Cannulated Instruments - Cleaning of 08/2022
15.04 Infection Prevention Control - HICMR Policies and Services 4/2023
12.03 Loan Sets - Operating Theatre 07/2022
2.76 Notifiable Infections Diseases 09/2023
6.23 Personal Protective Equipment (PPE) 12/2020
15.08 Respiratory Protection Policy- Fit Checking and Fit Testing of P2 and N95 Respiratory Masks 06/2023
15.03 Standard and Transmission Precautions 02/2023
1.49 Waste Management 06/2022
Local Site policies
Infection Control Policy - Multidrug Resistant Organisms - Patient Surveillance and Management
Training is completed via eLearning with competencies completed as stipulated by policy and monitored by management.
BPH Infection Control Education Plan.

Rating

Met

Findings

-

Action 3.02

The health service organisation:

a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems

b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections

c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections

d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship

e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities

f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship

g. Plans for public health and pandemic risks

Evidence Reviewed

Governance of the Infection Prevention and Control standard is provided through the Infection Control Committee (ICC) and the Antimicrobial Stewardship (AMS) Committee which has an extensive membership including Infectious Disease Physician, Infection Control Coordinator, Microbiologist (Pathology Company), Clinical area NUMS and the Educator. There are documented terms of reference. Infection Control Committee TOR 12/22 and AMS TOR 12/2019.

Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023 and AMS minutes dated 7/12/2023.

Brisbane Private Hospital utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR) to ensure practices are congruent with ACORN, and other relevant infection control standards which consists of a second yearly onsite review with the last review 2022. The review is primarily focused on the high risk areas with an action plan developed with documented actions/outcomes.

Risks associated with infections antimicrobial stewardship risks are managed through the risk register with regular reviews conducted to ensure appropriateness.

Training is completed via eLearning with competencies completed as stipulated by policy and monitored by management.

BPH Infection Control Education Plan.

Rating

Met

Findings

-

Action 3.03

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of infection prevention and control systems

b. Implementing strategies to improve infection prevention and control systems

c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems

d. Monitoring the effectiveness of the antimicrobial stewardship program

e. Implementing strategies to improve antimicrobial stewardship outcomes

f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes

g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources

Evidence Reviewed
There is a comprehensive audit schedule for Infection prevention and control systems and AMS which includes but not limited to transmission based precautions, hand hygiene audits, ANTT procedures, PIVC, and SNAPS. Results are reported through the Infection Control Committee and the AMS Committee and escalation to the Executive Clinical Governance Unit as required. Executive presents IPC and AMS data at the Medical Advisory Committee and CRAFT groups. Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023 and AMS minutes dated 7/12/2023.
Rating
Met
Findings
-

Action 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
The Patient Information Directory, which is provided to all patients at the time of their admission, contains a clear explanation of how consumers can be actively involved in their care from an infection prevention and management perspective (Hand hygiene, Food Safety and Cough Etiquette).Posters displayed in clinical areas include the importance of hand washing, cough etiquette and antibiotic usage. Brochures and Fact sheets are also utilised to communicate information e.g. Receiving Antibiotics in Hospital- Information for Patients and Carers. For many procedures, the take home post-operative instructions contain advice and information related to infection prevention and monitoring for signs of infection. Patients and staff interviewed by the Assessors were able to describe the actions taken to involve and inform them about infection prevention and control as well as AMS measures.
Rating
Met

Findings
-

Action 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Evidence Reviewed
Brisbane Private Hospital monitors and collects data on healthcare related infections and antimicrobial use as well as broader infection control surveillance data. Reports are reported through the Infection Control Committee and the AMS Committee and escalation to the Executive Team as required. Executive presents IPC and AMS data at the Medical Advisory Committee and CRAFT groups. Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023 and AMS minutes dated 7/12/2023. Clinical Indicators are submitted and benchmarked through ACHS - Report 1H 2023 sighted.
Rating
Met
Findings
-

Action 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Evidence Reviewed
The review of infection control documents specifically Transmission Based Precautions indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare standard. PPE stations have been installed in the clinical areas ensuring appropriate PPE is available at required. Communication processes are in place to ensure that all MRO is included in all documentation and communication. At the ward level signage is displayed on the patient door. Identified incidents/ issue are reported through the Infection Control Committee and escalation to the Executive team as required. Executive presents IPC and AMS data at the Medical Advisory Committee and CRAFT groups. Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023.
Rating
Met
Findings
-

Action 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission- based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions

Evidence Reviewed
The facility has policies and processes for the management of organisms-specific risks, including prevalence in the community is in place that are consistent with jurisdictional and Public Health advice. Fit testing is undertaken with current compliance noted to be low with a Program implemented and running to increase compliance Quality Improvement Plan # 4744. Adequate supply and use of PPE was observed to be appropriate. Documentation of infectious status is included with all documentation and communication is included in transfer of care and discharge processes. At the ward level signage is displayed on the patient door. Staff undertake mandatory training for the appropriate use of standard and transmission-based precautions. Processes are audited through the Preventing and Controlling Infections audit schedule. Identified incidents/ issue are reported through the Infection Control Committee and the AMS Committee and escalation to the Clinical Governance Unit as required. Executive presents IPC and AMS data at the Medical Advisory Committee and CRAFT groups. Infection Control Committee Meeting minutes sighted for 19/07/2023, 15/03/2023.
Rating
Met
Findings
-

Action 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Evidence Reviewed
Procedures are available for implementing standard and transmission-based precautions. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Documentation of infectious status is included with all documentation and communication in transfer of care and

discharge processes. At the ward level signage is displayed on the patient door. Brisbane Private Hospital has established a Water and Air Quality Meeting with documented TOR. The overall objective of this committee is to oversee and respond to non compliance as required . Meeting Minutes sighted 23/08/2023. There is a Water Management and Legionella Control Plan in place.

Rating

Met

Findings

-

Action 3.09

The health service organisation has processes to:

a. Review data on and respond to infections in the community that may impact patients and the workforce

b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care

c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection

Evidence Reviewed

Brisbane Private Hospital has implemented strategies so as to respond to public health requirements and direction with the Public health communicating community outbreaks alerts to the Executive Management team. Communication of a patient's infectious status is included at all transfer of care / handover points and compliance is monitored. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry points of patient care areas.

Rating

Met

Findings

-

Action 3.10

The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and:

a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements

b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative

c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups

d. Uses the results of audits to improve hand hygiene compliance

Evidence Reviewed

Initial Assessment: Brisbane Private Hospital has a documented Hand Hygiene Policy in place - 8.10 Hand Hygiene 07/2023. The Hand Hygiene program is consistent with the current National Hand Hygiene Initiative (NHHI) and jurisdictional requirements. The organisation has access to 11 Hand Hygiene auditors that have undertaken the NHHI training with plans underway to increase the number of assessors with transition to new Hand Hygiene Auditor Educator (HAE) model under NHHI.

Regular compliance and observational audits are undertaken and results are reported through the Infection Control Committee. Executive presents Infection Prevention and Control data at the Medical Advisory Committee and CRAFT groups.

Infection Control Committee Meeting minutes sighted for 07/12/2023 and 22/11/2023.

Hand Hygiene data is available on the facilities website and displayed on the Quality boards throughout the facility.

Hand Hygiene was noted to be poorly undertaken in several clinical areas despite overall compliance noted as 89%. Examples include ICU, Paediatrics, PACU and Main theatres.

Final Assessment: Evidence sighted at the final assessment the HSO has added four additional trained hand hygiene auditors with March education focus on Hand Hygiene.

Audits have continued with noted good compliance results- No missed moments identified whilst in the clinical area during the final assessment.

Rating

Met

Findings

-

Action 3.11

The health service organisation has processes for aseptic technique that:

a. Identify the procedures in which aseptic technique applies

b. Assess the competence of the workforce in performing aseptic technique

c. Provide training to address gaps in competency

d. Monitor compliance with the organisation's policies on aseptic technique

Evidence Reviewed
Processes for aseptic technique are in place. Staff are appropriately trained and competency / compliance is monitored. The Assessors were able to review audit results and identified training compliance. ANTT auditing is inclusive of the VMO. Aseptic technique management is addressed on the Risk Register - Risk # 17077 Aseptic Technique Risk # 18218 VMO Aseptic technique -training credentialed medical practitioners
Rating
Met
Findings
-

Action 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17
Evidence Reviewed
Training and assessment for the management of invasive devices are available to staff and align with the current best practice. Regular audits are conducted with results to the Infection Control Committee. HICMR PIVC audit report Jun 2023 sighted. Invasive devices management is addressed on the Risk Register - Risk # 17079 Invasive devices.
Rating
Met
Findings
-

Action 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 and jurisdictional requirements – to:

a. Respond to environmental risks, including novel infections

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

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

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

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

Evidence Reviewed

Processes to maintain a clean, safe and hygienic environment is managed internally. Cleaning procedures and schedules are in place with regular auditing and reports made available and reported through the committee structure. Cleaning schedules were sampled by the Assessors and staff interviewed regarding cleaning processes had a good knowledge and understanding of the cleaning requirements.

Training to the non-clinical staff in relation to cleaning processes for routine, outbreak situations and novel infections was evidenced.

Evidence sighted that disinfection using products are listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies.

An opportunity for improvement was raised to include the ARTG requirements in the corporate procurement policy.

Rating

Met

Findings

-

Action 3.14

The health service organisation has processes to evaluate and respond to infection risks for:

a. New and existing equipment, devices and products used in the organisation

b. Clinical and non-clinical areas, and workplace amenity areas

c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings

d. Handling, transporting and storing linen

e. Novel infections, and risks identified as part of a public health response or pandemic planning

Evidence Reviewed

Brisbane Private Hospital has infection control processes, policies and procedures to respond to infection risks for equipment, devices, products, buildings and linen that is responsive to novel infections risks and pandemic planning.

All new products are reviewed and assessed for infection related risk, this process is conducted in conjunction with the Corporate Procurement department. Linen is supplied by an external provider Ensign Services. During the assessment linen was observed to be managed and stored appropriately. Maintenance is both scheduled and responsive to failure with the use of Asset Plus to manage and monitor process.
Rating
Met
Findings
-

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
Initial Assessment: The risk-based workforce vaccine- preventable disease screening and immunisation program is consistent with the current edition of the Australian Immunisation Handbook. The Infection Control Coordinator maintains an Immunisation Register for staff with compliance currently at 89%. The Credentialing process does not describe the current requirements for seeking immunisation status from VMOs in accordance with the Australian Immunisation Handbook. Final Assessment: Evidence sighted at the final assessment that management has communicated to all VMOs of the requirement to provide proof of immunisation status to vaccine preventable diseases as well as COVID. The VMO training register with immunisation status is in place. As this process is in its infancy and not yet fully implemented a Met with Recommendations rating with remain.
Rating
Met with Recommendations
Findings
Evidence sighted at the final assessment that management has communicated to all VMOs of the requirement to provide proof of immunisation status to vaccine preventable diseases as well as COVID. The VMO training register with immunisation status is in place. As this process is in its infancy and not yet fully implemented a Met with Recommendations rating with remain.

Action 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Evidence Reviewed
There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. The program for workforce screening and workplace exclusion is aligned with Australian guidelines and Queensland Health directions. There is a Pandemic plan 2023. A tiered approach to outbreak and pandemic planning and management is in place.
Rating
Met
Findings
-

Action 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections

Evidence Reviewed
Initial Assessment: Brisbane Private Hospital has engaged the services of an external consultant - Andrew Gay from Sterilizer Validation Australian (SVA) to assist with the compliance to AS/NZ 4187:2014 (AS 4187) Standard. Flexible endoscope microbiological testing appears on a monitoring schedule, but evidence to confirm the tests were completed routinely was not available on the days of audit. An AS 4187 Action Plan has not been appropriately updated and reviewed in accordance with the plans for redevelopment on the documentation supplied at audit in accordance with Advisory 18/07 V10. Failed microbiological testing is not reported into RiskMan, therefore management governance of the process is unclear. Final Assessment: Evidence sighted at the final assessment that management have reviewed and revised as required the AS18/07 V10 Reprocessing of reusable Medical Devices. Gap Analysis against ACSQHC requirements with extension sought by Healthscope - sighted extension letter 3/11/2022. Endoscopy AS 4187 Gap Analysis 04/24 and CSSD AS 4187 Gap Analysis 4/24 sighted. Endoscopy/DSU refurb project due to complete end of January 2025 with work to commence in September 2024 if possible. Endoscopy refurb meeting minutes 23/04/24 sighted. ICC meeting minutes with discussion around Endo Refurb 23/04/24. Evidence sighted that a new revised microbiological testing schedule formulated for visibility of compliance with evidence sighted that scopes are tested three monthly with the Automated Endoscope Reprocessors (AER) tested monthly with all non compliance to be reported through RiskMan. Discussion with staff verified understanding of the process.
Rating
Met
Findings
-

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

Evidence Reviewed
The facility has established an antimicrobial stewardship program that is guided by evidenced based policy -policies have been provided to the organisation by Healthcare Infection Control Management Resources (HICMR) with a local site formulary in place. Discussion with the Infection Control Coordinator confirmed the prescribing process in accordance with the Therapeutic guidelines, list of restricted antimicrobials and approved processes with specialist or senior clinician review. Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use. Antimicrobial Stewardship - Guide for prescribers posters were displayed in the medication rooms and in the clinical areas and identifies highly restricted, restricted and unrestricted antimicrobials utilising traffic light system for antibiotic use. All staff has access to Therapeutic guidelines via the facilities intranet (HINT). Governance of the AMS program is provided through the AMS Committee which has an extensive membership which includes Infectious Disease Physician, Infection Control Coordinator, Microbiologist (Pathology Company), Clinical area NUMS and Educator. There are documented terms of reference in place 12/2019 v2 with the Committee meeting minutes sighted 7/12/2023.
Rating
Met
Findings
-

Action 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials

Evidence Reviewed
Governance of the AMS program is provided through the AMS Committee which has an extensive membership which includes Infectious Disease Physician, Infection Control Coordinator, Microbiologist (Pathology Company), Clinical area NUMS and Educator. There are documented terms of reference in place 12/2019 v2 with the Committee meeting minutes sighted 7/12/2023. Documentation showed that the antimicrobial stewardship program is audited to review the antimicrobial prescribing and use, including surveillance data on antimicrobial resistance. The program is evaluated and performance is monitored. Audits include SNAPS with results reported through the AMS Committee and escalation through the committee structure as required. Executive presents AMS data at the Medical Advisory Committee and CRAFT groups.
Rating
Met
Findings
-

Action 4.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Evidence Reviewed
Initial Assessment: The pharmacist was observed to write the medications of admitted surgical patients on the NIMC and the doctor signs the order the pharmacist has written. Pre-mediations are currently ordered on the anaesthetic chart not the NIMC. Final Assessment: Evidence sighted at the final assessment that management have conducted meetings with Medical Advisory Committee Chairman and the Pharmacy provider EPIC. Pharmacy is no longer writing up medications. Anaesthetic chart changed to national Healthscope HMR. Discussions at the Anaesthetic Meeting 26/03/2024 minutes sighted. Monitoring is ongoing via the auditing schedule.
Rating
Met

Findings
-

Action 4.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Evidence Reviewed
The medication system operates within a framework of quality improvement and includes the ongoing monitoring of both the effectiveness and performance improvement of medication management across the whole of the hospital. Strategies to improve the medication management system are introduced as evidenced with the “How are we doing” quality boards on each unit in public areas. The boards reflect all of the NSQHSS standards and are an initiative of the units to continuous improvement activities e.g., ensuring safety of paediatric medication administration including paediatric calculations are double checked, regular medication char audits including correct orders and labelling, implement education and learning from RiskMan medication incidents. The service maintains a quality audit program which provides safety and quality data for review and management through the committee frameworks, however, please refer to finding 1.08c for further comment
Rating
Met
Findings
-

Action 4.03
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
The HSO has a strong focus on the involvement of consumers, carers, and patients in medication management. Every effort is made by staff to ensure that there is a clear understanding of the effects of prescribed medications and their correct use during their stay and prior to patient discharge. Patients and/or

carers are encouraged to ask questions and importantly report any side effects or other reactions they may be experiencing. Patients can/are also provided with information in either verbal, written form, or both to inform them on any special instructions, directions and/or precautions. This information is made available to the carers and /or families who may be monitoring the administration of a patient's prescribed medication post discharge
Rating
Met
Findings
-

Action 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Evidence Reviewed
Processes are in place for ensuring that all relevant clinicians operate within their medicines scope of clinical practice. Any incidents that have been reported either as an incident or a near miss in either prescribing, dispensing and/or administration that may have occurred outside a clinician's scope of practice are subject to incident review, further reporting and when and if required further education.
Rating
Met
Findings
-

Action 4.05
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
Evidence Reviewed
Clinicians take a best possible medication history on admission utilising pre-admission information provided by the patient or their referring doctor. This may be taken and documented with input from a carer or family member. Patients, carers, and families are encouraged to be active participants if this is considered appropriate by both the patient and the clinician. Important information is documented on allergies and adverse drug reactions and is included within the healthcare record

Rating
Met
Findings
-

Action 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Evidence Reviewed
The review of prescribed medications against a patient’s initial best possible medication history is ongoing and forms part of the treatment plan for all patients. Interviews with the pharmacist confirmed that reconciliation processes are undertaken by either the pharmacist or the VMO with medication lists and related information being provided to the patient at discharge. Observational reviews verified medication management plans and their reconciliation.
Rating
Met
Findings
-

Action 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
Evidence Reviewed
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored (Alerts – Documentation and Management Policy and Medical Record Documentation audits). Discussion with staff and sampling of healthcare records routinely verified these processes. Interviews with management confirmed processes of ADR reporting to the TGA.
Rating
Met

Findings
-

Action 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Evidence Reviewed
The medication error reporting systems is maintained by a hospital-wide approach to supporting and encouraging reporting of medication adverse drug reactions in the incident management system (RiskMan) and entry to the healthcare record. Medication incidents form part of the overall safety and quality data that is reported through the HSO committee frameworks for review, investigation, management, and quality improvement.
Rating
Met
Findings
-

Action 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Evidence Reviewed
Policies and guidelines are in place to report adverse drug reactions experienced by patients in their care journey to the Therapeutic Goods Administration (TGA).
Rating
Met
Findings
-

Action 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Evidence Reviewed
Medication reviews are practised in line with best practice guidelines. Medication reviews may be based on a patient's clinical presentation, pre-admission medication prescriptions or due to a change in medication treatment.
Rating
Met
Findings
-

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

Action 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care

c. Provide patients on discharge with a current medicines list and the reasons for any changes
Evidence Reviewed
A component of discharge documentation is the provision of a current medicines list which is given to the patient on discharge. Interviews with the pharmacist confirmed that reconciliation processes are undertaken by either the pharmacist or the VMO with medication lists and related information being provided to the patient at discharge. Observational reviews verified medication management plans and their reconciliation.
Rating
Met
Findings
-

Action 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Evidence Reviewed
Routinely sighted in clinical areas access to eMIMS, Australian Injectable Drugs Handbook medication guidelines – Asthma and COPD medications, Therapeutic guidelines antibiotic.
Rating
Met
Findings
-

Action 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines

Evidence Reviewed
Initial Assessment: The pharmacist was observed to write the medications of admitted surgical patients on the NIMC and the doctor signs the order the pharmacist has written. Pre-mediations are currently ordered on the anaesthetic chart not the NIMC. Final Assessment: Final Assessment: Evidence sighted at the final assessment that all medication fridges are monitored manually with an electronic monitoring system currently being set up. Audits are conducted with oversight from management. Medication fridge checklists (DSU and PACU) checked during the final assessment with 100% compliance noted for completion. All medication was appropriately labelled.
Rating
Met
Findings
-

Action 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
Evidence Reviewed
Interviews with staff and supporting documents and assessor observations that high risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. Scheduled drugs are recorded in appropriate registers and are part of audit activities
Rating
Met
Findings
-

Action 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Evidence Reviewed
The requirements of this action are well supported by the management of Riverina Day Surgery through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards, support clinicians to deliver comprehensive care. Risks are managed through the risk register and updated as scheduled. Monitoring of events such as incidents, adverse events, and patient feedback is managed through the quality and risk management systems, reported through the committee framework. Training requirements have been determined with mandatory training modules being set. Monitoring of completion of these modules is maintained by the educator and unit managers with completion rates being tabled through the committee frameworks. Results are also included on the Safety and Quality Boards on each unit in common areas. Assessors reviewed the following policies at review Advance Care Directives, Alerts – Documents and Management, Comprehensive Care Plan, Delirium and Cognitive Impairment Prevention and Management, Falls Prevention and Management – Patient, Incident Management, Mandatory Training, Open Disclosure, Paediatric Clinical Assessment, Pressure Injury, Prevention and Management, Risk Management – Clinical
Rating
Met
Findings
-

Action 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Evidence Reviewed
Initial Assessment: Assessors were unable to verify the consistent monitoring and review of comprehensive care plans in the Damascus wards. The service maintains a quality audit program which provides safety and quality data for review and management through the committee frameworks, however, please refer to finding 1.08c for further comment.

Final Assessment: Evidence sighted at the final assessment that education has been undertaken with the staff on the Mental Health care plans. Care plans are reviewed at least weekly or more frequently if required. Discussion with staff, attendance at the MTD meeting and sampling medical records verified this process.

Monitoring will continue via the audit schedule.

Rating

Met

Findings

-

Action 5.03

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Staff were observed to actively involve patients in their own care and have a focus on inclusion and shared decision making, ensuring that the information provided is understood. Regular patient feedback with patient satisfaction surveys includes patient experiences in feeling supported and cared for and being involved in decisions related to their care. Interviews conducted with patients at the time of review consistently reported feeling involved in decision making related to their care.

Rating

Met

Findings

-

Action 5.04

The health service organisation has systems for comprehensive care that:

a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment

b. Provide care to patients in the setting that best meets their clinical needs

c. Ensure timely referral of patients with specialist healthcare needs to relevant services

d. Identify, at all times, the clinician with overall accountability for a patient's care

Evidence Reviewed

Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. Assessors reviewed the following policies at review Advance Care Directives, Alerts – Documents and Management, Comprehensive Care Plan, Delirium and Cognitive Impairment Prevention and Management, Falls Prevention and Management – Patient, Incident Management, Mandatory Training, Open Disclosure, Paediatric Clinical Assessment, Pressure Injury, Prevention and Management, Risk Management – Clinical, Transfer of Patient – Inter Hospital. The HSO operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processes for referral where needed. The clinician with overall accountability for a patient's care is defined as the admitting VMO

Rating

Met

Findings

-

Action 5.05

The health service organisation has processes to:

a. Support multidisciplinary collaboration and teamwork

b. Define the roles and responsibilities of each clinician working in a team

Evidence Reviewed

Initial Assessment: Following the review of a sample of inpatient Health Care Records and discussions with staff, inconsistent application of the Multidisciplinary Team clinical reviews for Damascus was identified.

Final Assessment: Evidence sighted at the final assessment that management has implemented a schedule for VMO's to conduct the MDT meetings. Attendance at the MDT meeting on the day of the final assessment verified processes have been implemented. Sampling medical records also verified processes.

The inclusion of the Patients three identifiers will strengthen the identification process.

Rating

Met

Findings

-

Action 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Evidence Reviewed
Roles and responsibilities are clearly defined through contracts and position descriptions, a system is in place for orientation, performance review and ongoing education.
Rating
Met
Findings
-

Action 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the ‘Minimising patient harm' criterion
Evidence Reviewed
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was routinely sighted in healthcare records
Rating
Met
Findings
-

Action 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Evidence Reviewed
The HSO has processes in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical care systems
Rating
Met
Findings
-

Action 5.09
Patients are supported to document clear advance care plans
Evidence Reviewed
Processes for routinely asking patient as to whether an Advanced Care Directive is in place were verified and sighted within patient healthcare records and consistent with 2.56 Advance Care Directives Policy
Rating
Met
Findings
-

Action 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks

Evidence Reviewed
The process for comprehensive screening is conducted during the admission process. Screening processes are in place for the identification of cognitive, behavioural, mental, and physical conditions, issues, and risks of harm. This information and collaboration with the patient are used in the development of the individual patient comprehensive care plan.
Rating
Met
Findings
-

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Evidence Reviewed
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Pre-admission processes were sampled during the assessment with evidence sighted that identified risks are communicated to the treating clinical team and accepting VMO's
Rating
Met
Findings
-

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Comprehensive screening is conducted during the admission process. Identified alerts are maintained on the Alert Sheet HMR 000 for communication to the treating team and were routinely sighted with sampling of healthcare records
Rating
Met

Findings
-

Action 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Evidence Reviewed
Initial Assessment: Goals of Care in paediatrics are sought and documented in overnight admissions, however partnering with families to set goals for day stay paediatrics is not fully implemented. Final Assessment: Evidence sighted at the final assessment that HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor on paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in Round Table meetings. Medical record review and discussion with staff verified that processes are in place and continue to be monitored through the auditing schedule.
Rating
Met
Findings
-

Action 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care

c. Review and update the comprehensive care plan if it is not effective

d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Evidence Reviewed

Initial Assessment: Goals of Care in paediatrics are sought and documented in overnight admissions, however partnering with families to set goals for day stay paediatrics in not fully implemented.

Final Assessment: Evidence sighted at the final assessment that the HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor on paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in Round Table meetings.

Medical record review and discussion with staff verified that processes are in place to identify goals for day stay paediatrics patient, however the evaluation of this process is not fully implemented.

Rating

Met with Recommendations

Findings

Evidence sighted at the final assessment that the HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor on paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in Round Table meetings.

Medical record review and discussion with staff verified that processes are in place to identify goals for day stay paediatrics patient, however the evaluation of this process is not fully implemented.

Action 5.15

The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care

Evidence Reviewed

The health service does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future

Rating
Not Applicable
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
The health service does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future
Rating
Not Applicable
Findings
-

Action 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Evidence Reviewed
Processes for routinely asking patient as to whether an Advanced Care Directive is in place were verified and sighted within patient healthcare records and consistent with 2.56 Advance Care Directives Policy
Rating
Met

Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Evidence Reviewed
The health service does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future
Rating
Not Applicable
Findings
-

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Evidence Reviewed
The health service does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future
Rating
Not Applicable
Findings
-

Action 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
The health service does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future
Rating
Not Applicable
Findings
-

Action 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Evidence Reviewed
The HSO has evidenced based tools for the screening and management of patients at risk of pressure injury and were sighted with sampling of healthcare records
Rating
Met
Findings
-

Action 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency

Evidence Reviewed
The use of the screening and assessment processes are in place for identification and management of patients at risk of developing pressure injuries. These plans form part of the overall patient comprehensive care plan and are monitored at regular intervals for their effectiveness or as changes occur. Processes sighted are consistent with 8.05 Pressure Injury, Prevention and Management Policy and Procedure.
Rating
Met
Findings
-

Action 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Evidence Reviewed
The HSO have appropriate equipment available to prevent and manage patients at risk of pressure injuries. Information on pressure injury and it management is also available to patients, their carers and families.
Rating
Met
Findings
-

Action 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management

Evidence Reviewed
The HSO has developed and implemented processes to support screening, assessment, and management of patients at risk of falls. All processes for the management of falls are articulated within the HSO's 8.04 Falls Prevention and Management Policy. The Risk Register outlines the organisational controls to assist in minimising falls. Interviews with the workforce verified post fall management which included use of allied health reviews post fall and entry into the incident management system for review by the committee frameworks. Current falls data is included on the Safety and Quality Boards on display on each unit.
Rating
Met
Findings
-

Action 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
Evidence Reviewed
The HSO have appropriate equipment and devices available to prevent and manage patients at risk of falls. Known risks of falls can also be included in the Alert Sheet HMR000
Rating
Met
Findings
-

Action 5.26
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Evidence Reviewed
Information on falls prevention and its management is available to patients, their carers and families and was routinely sighted on the units

Rating
Met
Findings
-

Action 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Evidence Reviewed
Any specific nutritional requirements held by the patient are identified at the pre-screening phase and are clearly documented in the healthcare records e.g., diabetic requirements. This information is communicated to catering to ensure the nutritional requirements of the patient are met.
Rating
Met
Findings
-

Action 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Evidence Reviewed
Any specific nutritional requirements held by the patient are identified at the pre-screening phase and are clearly documented in the healthcare records e.g., diabetic requirements, assistance with eating and drinking, gluten free. This information is communicated to catering to ensure the nutritional requirements of the patient are met. Patients identified with concerns of malnutrition are referred and assessed by dieticians

Rating
Met
Findings
-

Action 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Evidence Reviewed
The HSO has processes and procedures in place to support clinicians who are providing care to patients who have cognitive impairment or are at risk of developing delirium (8.94 Delirium and Cognitive Impairment Prevention and Management). Screening processes are in place for cognitive impairment with management protocols processes in place (MMSE, MSE)
Rating
Met
Findings
-

Action 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care

Evidence Reviewed
Initial Assessment: Cognitive risk assessments in day surgery patients are only completed if patients over 65 years have other co-morbidity as noted in HMR6.13G. This is not in keeping with the advice in the Delirium Clinical Care Standard, therefore the process is not fully implemented. Final Assessment: Evidence sighted at the final assessment that the HMR6.13G form was revised together with the policy and risk screening tool to comply with the Delirium Clinical Care Standard. Education provided to all staff rolled out. Sampling of medical records verified that appropriate cognitive risk assessment were undertaken.
Rating
Met
Findings
-

Action 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Evidence Reviewed
The HSO have processes in place to manage the identification of patients at risk of self-harm or suicide that safely and effectively respond to patients experiencing self-harm and suicidal ideation and is articulated in 8.45 Clinical Deterioration Recognising and Responding. Referral processes are available to assist with transfer to suitable clinical settings as required.
Rating
Met
Findings
-

Action 5.32
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

Evidence Reviewed
The HSO have processes in place to manage the identification of patients at risk of self-harm or suicide that safely and effectively respond to patients experiencing self-harm and suicidal ideation and is articulated in 8.45 Clinical Deterioration Recognising and Responding. Referral processes are available to assist with transfer to suitable clinical settings as required.
Rating
Met
Findings
-

Action 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Evidence Reviewed
The HSO have policies and procedures available to identify and mitigate situations that may precipitate aggression and is articulated 6.15 Occupational Violence and Aggression Management – Principles and Prevention and 1.11 Removal or Exclusion of Persons from Premises. Incidents of aggression or violence are entered into the incident management system for executive management and review\
Rating
Met
Findings
-

Action 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

Evidence Reviewed
Processes are in place for the identification and management of potential aggressive or violent behaviour. Staff were able to describe processes that work with patients to minimise aggression and potential violence. All incidents involving aggression are reported through the incident management system RiskMan for further review and management. Emergency Procedures Flip Charts and alarms are in place for emergency responses and noted quiet spaces within the facility to assist with de-escalation processes
Rating
Met
Findings
-

Action 5.35
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body
Evidence Reviewed
The HSO processes surrounding the use of restraint in accordance with legislative requirements is included in 8.16 Restrictive Practices – Patient Restraint and 9.18 Restrictive Practices – Restraint in of Voluntary Patients in Mental Health Facilities
Rating
Met
Findings
-

Action 5.36
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation

c. Report use of seclusion to the governing body
Evidence Reviewed
Not applicable as per the requirements of AS18/01
Rating
Not Applicable
Findings
-

Action 6.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Evidence Reviewed
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. Assessors viewed supporting documentation and witnessed various processes related to clinical communication 2.45 Alerts – Documents and Management, 8.18 Clinical Handover – Department and Intra Unit, 2.17 Consent to Medical/Surgical Treatment, 2.50 Discharge of a Patient, 0.21 Healthscope Privacy, 2.39 Medical Record – Documentation, 2.30 Open Disclosure, 2.49 Transfer of a Patient- Inter Hospital, 2.29 Risk Management - Clinical, 2.08 Patient Identification Bands
Rating
Met
Findings
-

Action 6.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes

b. Implementing strategies to improve clinical communication and associated processes

c. Reporting on the effectiveness and outcomes of clinical communication processes

Evidence Reviewed

Monitoring the effectiveness of clinical communication. Incidents relating to failure in clinical communication are reported through the incident management system and identified via patient feedback and variations in clinical processes. This assists in the development of improvements and changes in communication strategies and processes. Strategies to improve the Handover processes are introduced as evidenced with the “How are we doing” quality boards on each unit in public areas. The boards reflect all of the NSQHSS standards and are an initiative of the units to continuous improvement activities e.g., bedside handover and discussing with patients, checking charts, checking patient identification bands, safety huddles. The service maintains a quality audit program which provides safety and quality data for review and management through the committee frameworks, however, please refer to finding 1.08c for further comment

Rating

Met

Findings

-

Action 6.03

Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

The HSO has procedures and policy that support the engagement of patients, their carers and families in their own care and shared decision-making process. Patients are involved in clinical handover and verification of this was witnessed by the Assessors. Patients who were interviewed reported being engaged in their care and that they had adequate information available to them to make informed decisions about their care or ask further questions. Involvement in decisions is a set criterion in the Patient Satisfaction measured and displayed in each unit on the Safety and Quality Boards

Rating

Met

Findings

-

Action 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Evidence Reviewed
The HSO has policies and processes in place to support the use of appropriate identifiers for effective clinical communication. Documentation sampled by the Assessors supports the use of specified identifiers as per 8.18 Clinical Handover – Department and Intra Unit and 2.08 Patient Identification Bands
Rating
Met
Findings
-

Action 6.05
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
Evidence Reviewed
Initial Assessment: Assessors could not consistently verify anaesthetist participation in patient identification procedures during all episodes of care, examples included medication administration and handover to PACU. Noted there was participation in the time out processes sampled. It is also noted that QML Pathology only use two identifiers for patients in the blood register. Final Assessment: Evidence sighted at the final assessment that management discussed the requirements with the Medical Advisory Committee Chairman. Staff underwent training on "Speak up for Safety" . Anaesthetist was observed to participate in clinical handover in the PACU during the final assessment.

Audit process of Clinical Handover now includes the anaesthetist which will continue to be monitored.

Rating
Met
Findings
-

Action 6.06
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care
Evidence Reviewed
The Assessors noted the use of approved patient identifiers throughout the facility during the assessment. Additionally, processes are in place for surgical / procedural time-out, this is documented and audited. Healthcare records sampled by the Assessors verified this process.
Rating
Met
Findings
-

Action 6.07
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover

Evidence Reviewed
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient as well as the clinicians involved in the handover with operational guidance articulated in 8.18 Clinical Handover – Department and Intra Unit for consistency in approach. This includes the use of ISoBAR framework which has been implemented as a standardised approach to communication. Compliance with these requirements is party of the audit program with variations being reported through the committee frameworks. Staff interviewed could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover. The assessors observed clinical handovers throughout the facility, involving doctors, nurses, patients, and carers and confirmed the documented processes.
Rating
Met
Findings
-

Action 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Evidence Reviewed
Initial Assessment: Communicating the goals of care in day stay paediatrics during transitions of care is not fully implemented. Final Assessment: Evidence sighted at the final assessment that HSO has implemented a Paediatric patient care plan for day patients with education provided to the staff on B Floor on paediatric patient goals and documentation. Paediatric specific care boards have been developed and are now in place to facilitate goal setting and communication of goals with staff, patients and their families. Audits are conducted with NUMS discussing compliance results weekly with staff. Results are also discussed in Round Table meetings. Medical record review and discussion with staff verified that processes are in place and continue to be monitored through the auditing schedule.
Rating
Met

Findings
-

Action 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Evidence Reviewed
The HSO has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Clinical handover involves patients, their carers and families as required. Clinical handover is audited, and incidents / feedback related to communication issues are addressed through the committee frameworks. Bedside Handovers are a set criterion in the Patient Satisfaction measured and displayed in each unit on the Safety and Quality Boards.
Rating
Met
Findings
-

Action 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Evidence Reviewed
Observed by the assessors throughout the review processes for patients, carers and families to directly communicate critical information and risks about their care. These opportunities were noted at assessment and admission, bedside handovers, and the patient's care board. Posters alerting patients, family, and carers on communication to the clinical team in the escalation of care were noted in all areas of the hospital, including patient rooms
Rating
Met

Findings
-

Action 6.11
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan
Evidence Reviewed
Clinical documentation reviewed by the assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information and the recording of this in the patient healthcare record. Monitoring of the healthcare records is part of the auditing schedule with data for review and management through the committee frameworks, however, please refer to finding 1.08c for further comment
Rating
Met
Findings
-

Action 7.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Evidence Reviewed
Healthscope Ltd have implemented a number of Corporate Policies for blood management. The systems and processes are based on best practice guidelines and industry standards supporting clinicians to deliver blood management. Risks are managed through the risk register with regular reviews conducted to ensure appropriateness. Risk # 7640 Blood or Blood Product/component - incorrect product

Risk # 13882 Blood Safety -inadequate management of
Risk # 16808 Emergency Blood Management
Risk # 16809 Massive Blood Management
Training is completed via an eLearning platform and monitored via DASH.
Policies sighted
8.64 Blood Transfusion - Management of Patient , Blood and Blood Products 09/2023
8.62 Blood Transfusion - Massive 11/2021
8.63 Blood Transfusions (Emergency) of unmatched Red Cells 11/2021
8.64a Blood Fridge Management and unused blood products 11/2020

Rating

Met

Findings

-

Action 7.02

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:
a. Monitoring the performance of the blood management system
b. Implementing strategies to improve blood management and associated processes
c. Reporting on the outcomes of blood management

Evidence Reviewed

Brisbane Private Hospital utilise two main pathology companies Sullivan Nicolaides Pathology (SNP) and QML Pathology to provide the hospital with blood products.
There is a blood Fridge maintenance record with daily, weekly alarm check in place which is maintained by the Hospital Nurse Coordinator to ensure the cold chain management process is maintained. The hospital conducts regular compliance audits for each standard with results reported through the committee structure - Refer to 1.08.
ID # Blood Transfusion Audit completed 6/23 with a compliance of 97% achieved.

Blood wastage is reported through to the Peri-operative Meeting with minutes sighted 22/11/2023.

An opportunity for improvement was raised during the assessment to ensure the checklists used for high risk temperature sensitive storage (i.e. blood fridge) in the hospital are monitored for completion.

Rating

Met

Findings

-

Action 7.03

Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this and patients reported that they felt actively involved and informed about their care. There is a separate blood Consent for Blood and Blood Products in place with Patients receiving an information brochure to assist with decision making utilising the Red Cross Consumer blood transfusion information brochure.

Rating

Met

Findings

-

Action 7.04

Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by:

a. Optimising patients' own red cell mass, haemoglobin and iron stores

b. Identifying and managing patients with, or at risk of, bleeding

c. Determining the clinical need for blood and blood products, and related risks

Evidence Reviewed
It was observed that Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products. Optimising patients' own red cell mass, haemoglobin and iron stores is undertaken by VMO who prescribe iron supplements and Iron infusions as required . Ordering of blood and blood products is at the discretion of the VMO and is primarily driven on patients presentation and clinical assessment. During the time out process there is provision for the team to identify patients at risk of bleeding and this is an inclusions of the surgical safety checklist. Determining the clinical need for blood and blood products, and related risks is again at the discretion of the VMO and is documented in the patients medical records.
Rating
Met
Findings
-

Action 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Evidence Reviewed
Medical record review provided evidence that Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record (MRN # 500161 and MRN # 507823 and MRN # 3385).
Rating
Met
Findings
-

Action 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria

Evidence Reviewed
Brisbane Private Hospital has processes and procedures in place to support clinicians in the safe and appropriate practice of prescribing and administering blood and blood products. Medical record review provided evidence that Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record (MRN # 500161 and MRN # 507823 and MRN # 3385). The use of the blood and blood products prescription and transfusion record assists wit this criterion.
Rating
Met
Findings
-

Action 7.07
The health service organisation uses processes for reporting transfusion- related adverse events, in accordance with national guidelines and criteria
Evidence Reviewed
Brisbane Private Hospital has processes in place for reporting of transfusion-related adverse events which are consistent with national guidelines and criteria. RiskMan is utilised to report all incidents inclusive of transfusion- related adverse events.
Rating
Met
Findings
-

Action 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Evidence Reviewed
Hemovigilance activities are conducted through Queensland Health and are consistent with the national framework. Blood wastage is reported and monitored through to the Peri-operative meeting with minutes sighted 22/11/2023. The facility also stocks a limited stock of prothrombinex- VF.
Rating
Met

Findings
-

Action 7.09
The health service organisation has processes: a. That comply with manufacturers' directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Evidence Reviewed
Brisbane Private Hospital together with the Pathology companies Sullivan Nicolaides Pathology (SNP) and QML Pathology has processes in place to comply with manufacturers directions and be able to trace blood and blood products from entry into the facility including blood fridge temperature records and a blood registers. Service reports for the Blood Fridge S/N LW20061935 was sighted, CSK Group dated 3/05/2024. The assessor had the opportunity to sight the blood register, which contains the Patient name , DOB, MRN, Donor Number, Unit Number, Unit group and Product for SNP derived products. It is also noted that QML only use two identifiers for patients in the blood register. The Register also contains "Product Fate" column to be completed when collecting blood product for a patient or returning to the provider.
Rating
Met
Findings
-

Action 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage

Evidence Reviewed
Brisbane Private Hospital has process in place to manage the availability, eliminate waste and respond in times of shortage through 24 hour access to the Pathology Companies. The facility eliminates avoidable wastage by stocking only four units of O negative blood with monitoring of the expiry date and if not used returning to the Pathology Company.
Rating
Met
Findings
-

Action 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Evidence Reviewed
The recognition and response to acute deterioration policies and procedures are in place, known by staff and utilised as needed. Healthscope has implemented a number of Corporate Policies for recognising and responding to acute deterioration with some local site policies implemented to support the various specialities provided by Brisbane Private Hospital e.g. Paediatric, ICU, Drug and Alcohol. Internal transfer is readily available to the most appropriate acute ward should this be needed i.e. ICU. Training and education are in place and consistent with both clear outcomes and competency measures in place. Risks are managed through RiskMan with frequency of reviews depending on risk level. Risk # 7598 Clinical Risk Assessment and Levels of Observations - non compliant Risk # Deteriorating Patient - Delay or failure to call/escalate care Risk # Deteriorating Patient/escalation of care be it clinical review or MET call-inadequate Medical Record documentation Risk # Paediatric Emergency Management -inadequately managed Policies sighted 8.88 Anaphylaxis Management 7/2023 8.42 Basic Life Support (BSL) and Cardiopulmonary Resuscitation (CPR) 10/2022 8.45 Clinical deterioration - Recognising and Responding to 10/2022 8.94 Delirium and Cognitive Impairment Prevention and Management 07/2022

2.49 Transfer of a Patient - Inter-Hospital 07/2023

Local Site Policy

Local Rapid Response System Policy, including Mental Health 11/2023

Rating

Met

Findings

-

Action 8.02

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring recognition and response systems

b. Implementing strategies to improve recognition and response systems

c. Reporting on effectiveness and outcomes of recognition and response systems

Evidence Reviewed

Initial Assessment: The monitoring of the recognition and response systems occurs via the incident management system (RiskMan), the auditing platform MARS, eQuaMS and through the Committee framework. Brisbane Private Hospital enters data on all MET calls into the RiskMan system these are investigated and reported on through the governance structure. Reporting occurs at the Clinical Deterioration Committee Meeting with minutes sighted 12/12/2023 and then escalated up through the Patient Care Review Committee and the Morbidity and Mortality Meeting as required. The hospital conducts regular compliance audits for each standard with results reported through the committee structure - Refer to 1.08

A recent quality activity seen the introduction of the Children's Resuscitation Emergency Drug Dosage Resources.

Paediatric trolley was located in the storeroom obstructed by drip poles and equipment. There were lists for children in progress on the day of assessment.

No medications are located on the paediatric emergency trolley in PACU and does not have a tamper proof seal insitu.

The assessor was unable to verify the monthly checks performed on the Paediatric Trolley emergency medications.

The resus trolley for endoscopy and DSU is located in the endoscopy suite but is only checked on the days endoscopy is working.

Final Assessment: Evidence sighted at the final assessment that management have purchased two Broselow trolleys for PACU and B floor inclusive of emergency drugs and a tamper proof seal. The paediatric emergency Intubation trolley is now located in the PACU area. The Anaesthetic Chair reviewed all contents and checklists of the Broselow trolley. Checklists sighted on the day of the assessment were noted to be complete.

A second resuscitation trolley was purchased with Day Surgery now having their own trolley.

Rating
Met
Findings
-

Action 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Clinicians actively involve patients in their own care and have a focus on inclusion and shared decision making, ensuring that the patient can comprehend the information being shared and this was observed during assessment. The patient experience surveys provides BPH with data on patient's involvement in clinical decision making as one aspect of their episode of care and is reported throughout each department via Safety and Quality Boards with the Hospitals overall Safety and Quality Board recording a 78.5% rating. Patients were observed to be involved in Clinical Bedside Handover utilising ISBAR and reported to the assessor that felt involved in their care and decision making.
Rating
Met
Findings
-

Action 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Evidence Reviewed
Initial Assessment: Brisbane Private Hospital processes enable clinicians to detect acute physical and physiological deterioration by accurate documentation and the monitoring of vital signs. Individual patients are monitored by their own monitoring plan formulated, reviewed, and changed as required. Trending of the observations recorded on the Observation and Response Charts is inconsistently completed across multiple areas of the hospital. Final Assessment: Evidence sighted at the final assessment that targeted educational sessions have occurred (in-service sighted 05/03 on track and trigger charts) with March education sessions concentrating on resuscitation trolley and tracking & trending charting observations - auditing has been conducted and medical records sighted on the day of the assessment confirmed that this process is now implemented.
Rating
Met
Findings
-

Action 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Evidence Reviewed
Clinicians monitors performance of the identification and management of acute physiological, mental status, pain and / or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the Assessment Team, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and interventions are actioned in consultation with the treating team. Noted that the ICU observations charts do not have Patient triggers which has been addressed through the risk register Risk # 18235 ICU Observations Chart lack deteriorating Patient triggers with the introduction of a new ICU chart to be implemented in the coming Months.

Rating
Met
Findings
-

Action 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Evidence Reviewed
Policies, protocols, and clinical documents identify and include triggers for escalating care including vital sign, pain, distress, and clear parameters for initiating a MET call.
Rating
Met
Findings
-

Action 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Evidence Reviewed
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Assessors observed "Escalation of Care" posters all patient rooms and clinical waiting areas.

Rating
Met
Findings
-

Action 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Evidence Reviewed
The facility has processes in place to escalate care and/or initiate any emergency response. Clinicians are well trained with management plans and policies in place. Equipment and emergency trolleys are standardised with checklists records maintained.
Rating
Met
Findings
-

Action 8.09
The workforce uses the recognition and response systems to escalate care
Evidence Reviewed
Escalation of care processes and procedures are in place, known by staff and used as necessary. Clinicians have ongoing training to ensure they provide the correct response to all medical emergencies.
Rating
Met
Findings
-

Action 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Evidence Reviewed
Timely response of MET calls are measured and reviewed after every response with all responses entered into RiskMan and are subject to investigation and reported through the Committee Structure. There is a Resident Medical Officer on site at all times. The facility has a Hospital Nurse Coordinator rostered on duty at all time with ALS and PALS training.
Rating
Met
Findings
-

Action 8.11
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
Evidence Reviewed
Deteriorating in the physiological and mental state of the patient was consistently managed with appropriate policies and procedures available on the facilities intranet. The facility have an ICU with a number of staff trained in ALS and PALS . There is a Resident Medical Officer on site at all times. The facility has a Hospital Nurse Coordinator rostered on duty at all time with ALS and PALS training.
Rating
Met
Findings
-

Action 8.12
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Evidence Reviewed
There are processes in place to ensure timely referral to mental health services if such an event occurred. Although the facility has a Drug and Alcohol Unit, acute admissions for mental health conditions outside of this is not accepted.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Evidence Reviewed
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. The facility has the capacity to transfer patients to ICU. Staff were able to explain these processes to members of the Assessment Team.
Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable