National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Final Report

Darwin Private Hospital

Tiwi, NT

Organisation Code: 620277
Health Service Facility ID: 101249
ABN: 84 009 653 712
Assessment Date: 09-11 July 2024

Accreditation Cycle: 2

Contents

Introduction

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

ACHS is approved to accredit the following standards

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

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

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

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

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

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

The Commission works in four priority areas:

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

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

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

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

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Anne Zandegu	Yes
Assessor	Judith Dixon	Yes
Lead Assessor	Kim Darby	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Darwin Private Hospital. The accreditation decision was made on 09/08/2024 and Darwin Private Hospital was notified on 09/08/2024.

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Darwin Private Hospital underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 9/7/2024 to 11/7/2024. The NS2.1 Short Notice Assessment required three assessors for a period of three days. Darwin Private Hospital is a private health service and was last assessed from 22/6/2021 to 24/6/2021.

The PICMoRS (Process; Improvement; Consumer participation; Monitoring; Reporting and Systems) methodology was used to conduct this assessment, with 80% of assessor time spent in operational areas.

Governance of Darwin Private Hospital (DPH) is through Healthscope with onsite executive lead by the GM. Corporate strategies priorities and strategic directions are set in consultation with the governing body and the GM and reflect the community needs of the DPH catchment community. Contractual arrangements allow for the treatment of public patients from Royal Darwin Hospital in the DPH facility.

Patient safety and quality systems are implemented across DPH with the GM providing monthly reports to the governing body containing safety and quality information, inclusive of progress being made against the strategic priorities of DPH. There is an effective committee structure within DPH which ensures the flow of key information both within DPH and the governing body and external stakeholders. A high-risk scenario focused on the risks associated with provided services using the hydrotherapy pool and this scenario followed the PICMORs methodology.

Clinical performance and effectiveness are assured by a skilled workforce with sound recruitment processes, and effective training and performance management processes. Where applicable, DPH has implemented the Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care (the Commission), and these tools are effectively used to monitor safety and quality of services.

DPH provides a safe environment for patients, visitors and staff and is a well-maintained facility. The age of the facility and demanding environmental conditions provide significant challenges in maintaining the facility and robust preventative maintenance programs are required.

The DPH executive ensure that systems are maintained to partner with consumers. It was clear that patients were involved in their own care and were aware of their patient rights, with care planning undertaken in consultation with the patient and family where possible. Patient information is tailored to the diversity of the community and interpreter services are accessed when required. Consumers review patient information and provide advice during the development of this literature.

There are governance systems for the prevention and control of infections, and antimicrobial stewardship. Infection control and antimicrobial stewardship procedures are audited to ensure that there is compliance with policy guidelines. Patient facing information is accessible and written in plain language. Healthscope and Healthcare Infection Control Management Resources (HICMR) policies and procedures guide practice, and training is appropriate across clinical and non-clinical areas.

Surveillance data is collected, and appropriate remediation work completed when required. Hand hygiene compliance has been submitted to Hand Hygiene Australia for benchmarking purposes, and audit results are good.

DPH is well maintained, with attention to cleaning, food services and waste management being sound. There is appropriate management of linen, maintenance and repairs of infrastructure and equipment, and monitoring of water quality.

Workforce screening and immunisation meets relevant Northern Territory requirements. Infections within the workforce and community continue to be managed with the Northern Territory and Healthscope's guidelines.

DPH has recently commissioned a brand new Central Sterilising Department and are working towards being compliant with AS 5369:2023.

The antimicrobial stewardship (AMS) program is managed by the DPH AMS committee. The requirements of the AMS program, although met, show there is improvement required for medical prescribers to comply further with the AMS guidelines for appropriate use of antimicrobials.

Medication management services are contracted from HPS Pharmacy Services and provide services to DPH. The organisation is supported by Healthscope's systems for governance, and policy and guidelines. There are cohesive systems for all aspects of the medication pathway, and evidence of strong commitment to continuous improvement that engages all disciplines. During assessment, the process of prescribing, dispensing, administration and monitoring the effects of medicines were found to be part of everyday business.

Clinicians demonstrated an understanding of the principles of medication safety and were observed engaging positively with patients and carers on multiple occasions. Medicine information, alerts and guidance around medication was easily accessible and guided clinical practice.

Comprehensive care at DPH is governed by Healthscope policy and procedures. The Comprehensive Care Plan and associated risk screening tools have been reviewed and are shown to provide a collaborative tool for clinicians, patients and their families and carers. Patients are screened by the nursing staff on admission and when required throughout their admission for risks around cognitive impairment and delirium, medication management, malnutrition, falls, VTE, mental health, behavioural and substance withdrawal, and skin and pressure injury. Identified risks are managed appropriately. Systems are in place and audits conducted to manage these risks. A suggestion has been made in relation to ongoing audits of VTE documentation on the patient medication chart.

Patients and their families were observed collaborating with the clinicians in their care and understood their treatment options. There is a process for patients who have advance care directives and DPH has recently introduced End-of-Life Care Boxes to assist clinicians and patients with processes and care at this time in the patient journey. A suggestion was made to the Executive to investigate the Palliative Care Outcomes Collaborative (PCOC) to further assist the teams with management of patients requiring palliative care at end-of-life.

Clinical handovers, safety huddles and time-out processes observed demonstrated a collaborative approach between the patient and clinicians in relation to communicating for safe care. Overall, this was done well, however two areas that could be strengthened in relation to clinical handover were identified. One suggestion has been made regarding the ongoing education, auditing and monitoring of clinical handovers, to ensure that clinicians comply consistently with policy about the use of three identifiers. A second suggestion is in relation to ongoing monitoring of the timeliness of the discharge summaries to general practitioners.

DPH is supported by Healthscope policies in relation to the safe and appropriate use of blood and blood products. Patients give consent before the administration of blood products, and this was witnessed during the assessment. Consideration for patients refusing blood products is addressed through the 'Jehovah's Witnesses and other patients that refuse blood transfusions' policy and in-service education has been provided to key DPH staff by the Darwin Jehovah's Witnesses Church regarding blood and blood products.

Blood products are managed through the Royal Darwin Hospital Pathology Service and the only blood fridge at DPH is in the operating theatre complex. This fridge and the two units of O negative blood that are kept there are monitored and stock is rotated by the Pathology Service. The Blood Transfusion Committee monitors the use of blood products and any adverse events within the organisation. A recent quality project by the committee saw a marked decrease in blood product wastage.

Policies and procedures are in place to provide guidance in responding to acute deterioration. The commitment of the leadership team and Rapid Response team to support the recognition of, and response to, acute deterioration in both physical and mental state, was noted. The organisation is well supported by the Royal Darwin Hospital for Code Blues, inclusive of mental health deterioration. MET Calls are reviewed, and information is fed back via the Medical Advisory Committee and the Safety and Quality Committee. The Patient and Carer Escalation of Care (PACE) is established, and encourages patients, families or carers to escalate care, activating an automatic clinical review to attend to the patient immediately.

Training needs include Basic Life Support (BLS), Advanced Life Support (ALS), Paediatric Life Support (PALS) and Neonatal Natal Resuscitation. Compliance for training was in the high percentile within Healthscope's benchmark, and mock cardiac arrest and training occurs throughout the year.

The observation charts are used well, and the use of modifications, when relevant, was noted. There are clear processes for escalating care and referral to mental health services, to meet the needs of patients whose mental state has acutely deteriorated.

There was compliance with all NSQHS Advisories and Fact Sheets. All Actions were confirmed as 'Met' and therefore there are no recommendations contained in this report. A number of suggestions have been made to encourage DPH to strive towards best practice.

Summary of Results

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

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

Sites for Assessment

Darwin Private Hospital

Site	HSFID	Address	Visited	Mode
Darwin Private Hospital	101249	Rocklands Drive TIWI NT 0810	Yes	On Site

Shared and Contracted Services

A sample of Contracts / Shared Services have been verified.

The following shared services are used by Darwin Private Hospital.

Provider	Description of Services	Verified During Assessment
NT Cardiac	Cardiac Cath Lab	Yes
Respiratory and Sleep Medicine	Sleep Studies	Yes

The following contracted services are used by Darwin Private Hospital.

Provider	Description of Services	Verified During Assessment
Medical Equipment Management	Biomedical Engineers/Medical Equipment	Yes
IR Electrical	Emergency Generator	Yes
Spotless Linen service (Corp contract)	Laundry	Yes
Ecolab (Corporate Contract)	Microbiological Analysis for Cooling Towers	Yes
NT Government - Royal Darwin Hospital	Oxygen, Biohazard waste	Yes
Australian Clinical Labs	Pathology	Yes
Rentokil (Corporate Contract)	Pest Control Service	Yes
HPS Pharmacies	Pharmacy	Yes
Print Media Group/E-Print/Vistaprint	Printing Medical Records	Yes
iMed	Radiology	Yes
Wilsons Security	Security	Yes

Provider	Description of Services	Verified During Assessment
WINC	Stationary	Yes
Cleanaway	Waste Management	Yes
BOC Corp and Cor Gas	Medical gases	Yes
Eco Building	Air Con	Yes
IR Electrical	Electrician	Yes
OTIS	Lifts	Yes
IT Healthscope (Progility)	Phones	Yes
Aus Plumb	Plumber	Yes
Eco Building	Chillers	Yes
Raulands	Nurse Call	Yes
Defend Fire	Fire Services	Yes
Rentokil (Corporate Contract)	Sanitary Bins	Yes
Grace	Document Storage - off-site	Yes
Territory Pathology	Pathology	Yes

Darwin Private Hospital has reviewed these agreements for the listed services in the three years preceding this assessment.

Standard 1 - Clinical Governance

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

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Comments	
The DPH executive has created a very good culture of safety and quality within Darwin Private Hospital (DPH), and it was clear that staff understood their roles and responsibilities and that effective leadership was provided by the governing body. Documented priorities and strategic plans are developed at a corporate level by Healthscope and can be tailored to include local strategies. There is regular reporting through the Healthscope structure and feedback mechanisms to the DPH executive. There is an excellent relationship with the Royal Darwin Hospital (RDH) and this ensures that the community has access to a range of services across the public and private facilities. A clinical governance framework identifies the safety and quality systems that are used to monitor, identify and act on issues impacting patient care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
A Reconciliation Action Plan has been developed at the corporate level and a First Nations Engagement Plan is being finalised from this document. These documents outline the safety and quality priorities for Aboriginal and Torres Islanders as they apply to the DPH community. People identifying as Aboriginal and Torres Strait Islander make up approximately 7% of DPH activity, and DPH may have one of the highest activity levels from this group across Healthscope facilities. DPH should continue to ensure that corporate initiatives are implemented within DPH with a priority consistent with patient activity. The requirements of Advisory AS18/04 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
It was evident that systems within the clinical governance framework were implemented effectively within DPH. The DPH committee structure provides the framework for reporting on safety and quality systems and a mechanism for the ongoing monitoring of performance indicators, and there are clear lines of escalation if issues arise.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.04	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
Strategies from the DPH First Nations Engagement Plan will be monitored through the executive and progress reported by the GM through to the Healthscope management structure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
It was evident from discussions with the executive, GM and clinicians that safety and quality of patients is a priority when business decisions are being made. This culture is reflected in committee minutes and ensures a strong culture of safety exists throughout DPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
Clinical leaders across DPH provided strong and effective leadership and support to clinicians to ensure the safety and responsibilities flow through to patient care. Although many of the clinical leaders are new to their role, they will further develop skills and provide strong leadership to both experienced clinicians and newly graduated health professionals.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Comments	
The DPH system for maintaining policies and procedures ensures that clinicians have access to current documents to guide the decision-making processes for good clinical care. The Healthscope corporate team support DPH to review compliance with legislation and jurisdictional requirements and clinicians within DPH participate in the whole of Healthscope review of these documents. Ongoing audit processes are used to monitor compliance with policy and processes and action is taken when areas for improvement are identified.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Comments	
The quality improvement system is documented within the RiskMan system, through the eQuaMS register. While this system may not be user-intuitive, it does contain all the information pertinent to quality activities and a sound tracking system for progress with identified improvements. Clinicians were familiar with the system and its use in driving improvement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.09	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	
DPH has an effective reporting system to provide timely reports on safety and quality. A DPH committee structure ensures that issues are monitored at point of care and escalated through to committees, staff meetings and daily huddles, as appropriate. The GMGMGM has regular contact with Healthscope Corporate and provides a formal month-end report with a comprehensive overview on new issues and updates on outstanding issues. This ensures that key activity and financial performance indicators are monitored and reviewed, and variances identified and actioned.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Comments	
DPH maintains a risk register which captures all risks and contingency actions to minimise risk. The system is known to staff and monitored to ensure mitigating strategies are implemented effectively. A high-risk scenario in accordance with NSQHS Fact Sheet 14 followed the PICMoRS methodology and focused on the risks associated with providing services in DPH hydrotherapy pool. This exercise provided the opportunity to see how the risk system was used and showed that the risk system contained all the elements required of this Action.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Comments	
Incidents are reported and monitored through the relevant committee structure and processes have been developed to ensure all incidents and near misses are captured. Serious outcomes are trended and monitored, with progress and updates provided by the GM within the DPH month-end report.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
Processes are consistent with the Australian Open Disclosure Framework. Staff receive training in open disclosure and records are maintained where open disclosure processes have been implemented. Records confirmed patient and family involvement and outcomes from these processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
Processes and outcomes from the feedback and complaints management system are used to drive improvements in safety and quality.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system
Comments
A complaints and feedback register is maintained which is a comprehensive register of all noted issues and it was evident that minor and more significant issues were captured. It was also evident that patients and families were aware of mechanisms to report issues, with records maintained to track and monitor on outcomes.
Suggestion(s) for Improvement
Increase the auditing of timeframes of completion for each step of the complaint resolution process to ensure that those who have raised issues are aware of progress in resolving those matters.

Rating	Applicable HSF IDs
Met	All

ACTION 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care
Comments
Systems are developed to identify the diversity of consumers and those who are at a higher risk of harm. There is a very good relationship with the Royal Darwin Hospital which ensures that those at risk can be transferred to a more appropriate care setting where appropriate.

Rating	Applicable HSF IDs
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
The healthcare record is principally maintained as a paper-based system and is effective in providing information at the point of care. Regular audits are scheduled action is taken if the need for improvement in documentation and record maintenance is identified. Medical record storage takes security and privacy regulations int consideration.
Suggestion(s) for Improvement
Ongoing auditing has identified low compliance with the completion and inclusion of a medical discharge summary in the health care record. A review of the audit tool and use of that tool should be undertaken to ensure the audit process reflects actual completion rates and does not under-state compliance.

Rating	Applicable HSF IDs
Met	All

ACTION 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Comments
DPH uses a corporate Healthscope process to ensure the implementation of a system providing an appropriate level of clinical information into the My Health Record system.

Rating	Applicable HSF IDs
Met	All

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

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
An effective orientation program is available to all DPH stakeholders. Staff reported that the orientation program was effective in preparing them for employment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Comments	
Staff training needs are addressed in a mandatory training program, and completion rates are monitored and action taken to ensure staff have access to training programs when needed. At the time of assessment, training rates were acceptable.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
Staff have access to cultural awareness and cultural competency initiatives, while the Healthscope Reconciliation Plan identifies employment targets for people identifying as Aboriginal and Torres Strait Islander. DPH is currently exceeding that target. Healthscope sets an Australia-wide target, but given the relatively higher rates of admission of Aboriginal and Torres Strait Islander people at DPH than the Healthscope average, it may be expected that DPH seek higher rates of employment.
Suggestion(s) for Improvement
Consider including an aspirational target for Aboriginal and Torres Strait Islander employment in the DPH First Nation Engagement Plan that reflects the admission percentages of that group.

Rating	Applicable HSF IDs
Met	All

ACTION 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation’s training system
Comments
Staff are aware of the performance review processes and the completion rates are acceptable. This mechanism can flow into training programs and is an effective tool in assisting in the retention rates of employees.

Rating	Applicable HSF IDs
Met	All

ACTION 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Comments
The DPH Executive and the chair of the Medical Advisory Committee have roles in ensuring that clinicians are functioning within their scope of practice and that of the DPH clinical services plan. Scope of practice is monitored effectively, and this is evident both at the procedural point-of-care level, and executive level to ensure compliance with DPH role.

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
Medical Advisory Committee minutes and the credentialling policy and procedure provided evidence that the current practice ensured clinicians requiring credentialling were processed prior to commencement of service, and re-credentialed as appropriate.

Rating	Applicable HSF IDs
Met	All

ACTION 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Comments
Documents outlined the delegated safety and quality roles and responsibilities of the workforce, and staff described their responsibilities and observation of practice confirmed that.

Rating	Applicable HSF IDs
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
Clinicians have access to supervision and after-hours support as required. There is an excellent relationship with Royal Darwin Hospital to ensure that cooperation exists where escalation of care requires access to the most appropriate care setting.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
Guidelines, care pathways and decision-making tools are all readily available to clinicians. When ACSQHS Clinical Care Standards are issued, DPH implements those standards as applicable to their care setting. DPH was noted to be compliant with Advisory AS18/12.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Comments	
Variation to clinical practice is monitored by the Medical Advisory Committee and reported to the ACHS Clinical Indicator Program and to the Healthscope Corporate structure. Where variance is identified, initiatives are taken to improve outcomes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Comments	
The current infrastructure is well maintained and provides for a pleasant and welcoming environment. Recent new mental health facilities in the Darwin Clinic, and a recently opened CSSD, demonstrate a commitment to ensuring that facilities are fit for purpose and meet clinical need. There are significant pressures on the original infrastructure, particular on air-conditioning, in the demanding Darwin climate. Contract management processes were generally sound; however, an inconsistency was noted with managing the contract for Bio-Medical Engineering. During the assessment work commenced to address those issues.	
Suggestion(s) for Improvement	
While currently adequate, DPH should consider enhancing contract monitoring at a local level to ensure the needs of DPH are fully identified.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Comments	
There is an effective workplace inspection process that identifies areas of risk regarding unpredictable behaviour and strategies are developed as appropriate to mitigate that risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
Signage is fit for purpose and observation of patient and visitor flow provided evidence that the signage is effective.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
Visiting hours are flexible to meet the needs of patients and visitors.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
Aboriginal consumers and patients reported that a welcoming environment exists for Aboriginal and Torres Strait Islanders.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
Clinicians were observed using safety and quality tools identified in the clinical governance framework when partnering with consumers. At each interaction between staff and patient, it was noted that respect and dignity were paramount and an excellent rapport existed. Clinician access to policy, training and risk systems reflected the integration of clinical governance principles into point of care practice.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	
The principles of the quality improvement system are adopted when partnering with consumers. Monitoring of performance, evaluation of care and implementing strategies for improvement reflected the priorities of consumers and ensured that consumers were central to decision-making processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
DPH has a charter of rights that is consistent with the Australian Charter of Healthcare Rights which is easily accessible to patients and family. Discussions with clinicians, patients and families showed it was evident that the rights of patients were well understood.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.04	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	
Informed consent processes were witnessed and documentation in the health care record confirmed compliance with policy. Financial consent arrangements are consistent with Advisory AS18/10.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.05	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
Processes are implemented to identify the capacity of the patient to make decisions about their own care, and a substitute decision-maker is identified if required. Policy supports current practice.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
Tools to support shared decision-making are available and the health record showed that patients and family were involved in decision-making regarding the goals of care. Health care records verified that care plans are developed in consultation with patients and family.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.07	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Comments	
Strong partnerships are formed between clinicians and patients to ensure that all stakeholders are involved in the delivery of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.08	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
DPH has developed communication mechanisms that are tailored to the diversity of the community, including people identifying as Aboriginal and Torres Strait Islander. Cultural awareness training is available, and patient and family information packages can be accessed in different languages and accessible formats. Clinicians and admitting staff are aware of these resources and how to access this material.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.09	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
The Consumer Advisory Committee has members who are representative of the community DPH serves, and who are able to demonstrate their involvement in the development and review of patient information. Consumer representatives provided examples of where their input had resulted in changes to this material.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Comments	
Patients reported that information was provided in a format and style that was understood. A consumer representative has become involved in auditing the care boards within each patient room and providing advice to clinicians on issues that are important to patients. The completion of these care boards has improved in recent months and demonstrates the responsiveness of DPH to consumer input.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Comments	
There was evidence of consumer input at both the Community Advisory Committee level as well as that of individual consumers which ensured their input into the design and evaluation of care appropriate to the services provided. The Community Advisory Committee membership is representative of the diversity of the community and DPH seeks opportunities for community representatives to have a voice in decision-making.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	
Community Advisory Committee members described their orientation program and the ongoing opportunities available for them to gain further knowledge on how they may contribute to the consumer experience. Their involvement in the accreditation process provided further education on the role that consumers can play in DPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
The inclusion of a person who identifies as Aboriginal and/or Torres Strait Islander will provide further opportunities for DPH to work in partnership with communities to make a difference to the experience of community members.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
Members of the Consumer Advisory Committee have been invited to participate in orientation and ongoing training to better incorporate the consumer perspective into workforce training. The assessors encouraged members of the Committee to go beyond the current informal processes and become a permanent component of orientation and training programs.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
DPH infection control documents are aligned with the Clinical Governance Standard, and staff were observed operationalising practices consistent with the documented policies and procedures. The Infection Control Program supports consumers and health care workers by providing evidence-based practices, continuous monitoring, and includes training requirements for preventing and controlling healthcare-associated infections and effective antimicrobial stewardship. Staff described the implementation of related infection control policies and procedures and strategies to effectively mitigate risks. Infection prevention and control principles consistent with best practice are embedded in the orientation and ongoing training programs. The completion rate for hand hygiene mandatory training was noted to be at 96% in April 2024. A recent change to Healthscope's frequency of training has seen DPH fall below Healthscope's KPI target, and an action plan is in place to address this training requirement. Healthscope and DPH Infection Prevention and Control policies were noted to be consistent with the requirements of the 2021 edition Preventing and Controlling Infection Standard. The organisation is compliant with Advisory AS20/20.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
DPH has an Infection Control working group that forms part of the Safety and Quality Meeting, reporting to the Medical Advisory Committee, and which provides governance of the Infection Prevention and Control, Antimicrobial Stewardship (AMS) and reprocessing of reusable devices medical devices. DPH has governance structures in place to address and manage risks identified, with clear escalation and communication to support key areas of concern. Issues are discussed and documented at the relevant committees, and strategies identified to improve performance where gaps are identified. Terms of Reference are up to date, inclusive of the Safety and Quality Committee, Patient Care Review Committee, Medical Advisory Committee and AMS Working Group. There is a comprehensive audit schedule for infection prevention and control systems, and audit results are provided to individual units through relevant committees. These include environmental audits, antimicrobial audits, Bare below the Elbow audits, Indwelling Catheter Audits and Invasive Devices audits. HICMR, an external company which provide Infection Prevention and Control Management Services, audit DPH every two years, making recommendations for improvement which DPH actively address any non-conformances. AMS-informed practice is supported by Healthscope's AMS policy, and is also supported by the Royal Darwin Hospital AMS pharmacist and AMS medical officer, for advice regarding a patient's antimicrobial needs. Clinical staff described the equipment and educational resources required for Infection Prevention and Control and AMS. A Pandemic Risk Management Plan was sighted during the assessment.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Comments
As noted in the previous section, DPH has a comprehensive audit schedule to monitor compliance with infection prevention and control systems. Remedial action is taken in response to any lack of compliance, and action plans are put in place with accountability and responsibility for improvements. All breaches of compliance are reported to departments, wards and to the governing body. Evidence showed that the infection prevention and control program and AMS programs are monitored, with results and outcomes reported and discussed at the relevant committees. Communication is regularly sent out to all staff from the Quality Manager, to keep clinicians abreast of day-to-day changes, new strategies, and revised policies and procedures.

Rating	Applicable HSF IDs
Met	All

ACTION 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Inpatients reported that they are actively involved in discussions about infection control matters, managing infection risks and antimicrobial prescribing. Information is available to patients verbally and in relevant information resources. Staff have access to the infection prevention and control resources that are readily available on the HINT intranet and the L Drive. Staff also have access to print information for patients. This was confirmed by patients, who reported that the Nurse Unit Manager, medical officer or pharmacist would advise them about infection prevention and control practices, which included antimicrobial medications. The medical record notes documented discussions regarding treatment decisions, which included antimicrobials, and patient information around infection and use of antimicrobials can be easily downloaded from the L-Drive in a format that is easily understood.

Rating	Applicable HSF IDs
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
A wide range of data is collected regarding healthcare-related infections and antimicrobial use, as well as broader infection control surveillance data, and reports are provided to clinicians and through the governance structure. Data regarding SABSIs is discussed at the Patient Care Review Committee to review issues, and targeted actions plans are formulated. All data, including National Antimicrobial Prescribing Survey (NAPS) and National Antimicrobial Utilisation Prescribing Survey (NAUSP), which is benchmarked, are made available to staff and reported through established governance reporting structure. Current data supports the effectiveness of the organisation’s strategies.

Rating	Applicable HSF IDs
Met	All

ACTION 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Comments
DPH infection prevention and control processes are consistent with the Australian Guidelines of Infection in Healthcare, and transmission-based precautions are in place. Signage and other resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Compliance was confirmed with policy across the facility, with results reflected by the audits undertaken.

Rating	Applicable HSF IDs
Met	All

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Comments
DPH has an organisational response to manage risks related to specific organisms, including communicable diseases. These practices are consistent with Public Health Advice and jurisdictional requirements. Patients who present an infection risk are identified and appropriately placed into isolation according to mode of transmission. Practice is maintained with relevant information passed on to all patients and family members, which includes specifics relating to the type of isolation and precautions to be observed. Nurse Unit Managers meet with each patient to discuss specifics relating to the isolation precautions to be observed. Follow-up education regarding infection status is provided to patients, families, and visitors if required. Staff have access to appropriate PPE, and all staff have been provided with, and will continue to be provided with, donning and doffing education to ensure compliance with safe practice. Audits of practice reflect compliance. DPH has a Respiratory Protection program in place.

Rating	Applicable HSF IDs
Met	All

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Comments
Procedures and education are available to all clinical and non-clinical staff to ensure understanding and compliance with standard and transmission-based precautions. Staff confirmed their understanding of risk screening procedures to ensure a safe environment. A patient's infectious status is communicated to all key stakeholders and on transfer of care along the patient journey, as documented in the medical record and on WebPAS. DPH is compliant with Public Health jurisdictional requirements regarding notification of communicable or infectious diseases. Patients are placed in single rooms for ease of ensuring isolation procedures.

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	
DPH currently has approximately 18 FTE cleaners and staff to manage food services. Linen is contracted with 'Ensign' and waste is contracted by 'Cleanaway'. Cleaning and environmental practices were consistent with current cleaning standards, and audit results reflect good practice. All staff have access to hand sanitiser, which are located throughout the facility, and observed to be used frequently.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.09	
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection	
Comments	
DPH has policies and procedures which are consistent with national and jurisdictional guidelines to guide staff practice to ensure that a patient's infectious status is noted at all transitions of care. The patient's infectious status is recorded on WebPAS, the patient medical record, and on handover sheets. The patient's infectious risk was observed to be part of the transfer of relevant information at the bedside clinical handover process. Signage was strategically located at the entrance to isolation rooms. Patients and visitors are alerted to precautions that are required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Comments
DPH has a Hand Hygiene Program that is aligned to jurisdictional requirements and the National Hand Hygiene (HH) initiative. The organisation has 1 Gold Standard Hygiene Auditor. Regular Hand Hygiene audits are undertaken, with evidence reflecting overall compliance for Period 2 at 88%. Current compliance for Hand Hygiene training rates in April 2024, was above Healthscope's national target at 96%. A recent change in Healthscope's frequency of training has DPH catching up on the compliance for Hand Hygiene training. An action plan is in place to address this shortfall. Audit results are tabled at the Patient Care Review Committee and the Medical Advisory Committee.

Rating	Applicable HSF IDs
Met	All

ACTION 3.11
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Comments
Procedures that require aseptic technique have been identified, and DPH has processes that are supported by policy. The current completion rate for staff training in aseptic technique is 88.1%. The education team at DPH follow up with staff that require ANTT theory and practice competency assessment. Audit results indicated compliance with the requirements of aseptic technique.

Rating	Applicable HSF IDs
Met	All

ACTION 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare
Comments
Assessment of competency and training are aligned with current legislation and consistent with the Australian Guidelines for Prevention and Control of Infection in Healthcare for the management of invasive devices. Single use invasive devices are in place across the health service. Monitoring of compliance with storage is undertaken, and breaches addressed. Surveillance data of Healthcare-Associated Blood Stream Infections (HABSIs) attributed to invasive devices are monitored and reported via the governance structure. All blood stream infections are reviewed and reported to the Executive. A full investigation and analyses of data is undertaken, and relevant remedial action and strategies are implemented in response to the risk identified. The SAB rate at DPH is 0.48% per 1000 bed days.

Rating	Applicable HSF IDs
Met	All

ACTION 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
Comments
DPH have documented cleaning procedures schedules in place, ensuring that the hospital staff respond appropriately to environmental risks, including novel infections. All cleaning staff undergo a department specific orientation program, which ensures that expectations and requirements are clearly understood, and ongoing education provided to ensure understanding and compliance with cleaning standards. Cleaning and disinfection products used are consistent with manufacturers guidelines, and staff have access to QR codes for instructions in every cleaner's room. DPH uses Ecolab for all cleaning solutions. A comprehensive cleaning audit program is available, with regular audits conducted monthly by Infection Control and Housekeeping to monitor compliance with environmental policies and procedures. All reports are tabled and forwarded to relevant departments via the governance structure. Information derived from audits is used to inform the quality agenda and loaded into the eQUAMS system for recording.
Suggestion(s) for Improvement
Continue with the leadership audit to ensure all disposable patient curtains are dated correctly when curtains are changed.

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.14	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	
Comments	
DPH manages cleaning and food management services in-house. The linen contract is with Ensign and waste is managed by an external contractor (Cleanaway). Audits were of high standard and compliant with policy and procedure. Healthscope and DPH policy and procedures guide staff to effectively identify and respond to infection risks for new and existing equipment, products, devices, buildings and linen management. This includes responding effectively to novel infection and pandemic planning. Linen transport is compliant with standards. A preventative maintenance program is in place for all furniture, equipment and buildings. All types of waste were noted to be effectively managed.	
Suggestion(s) for Improvement	
Continue with the plans regarding the air conditioning upgrade and HEPA filter replacement program, and the perioperative Lino replacement program as needed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Comments
DPH vaccination requirements are consistent with the Australian Immunisation Handbook and Northern Territory guidelines. Pre-employment screening occurs for Category A, B or C, and staff are supported to complete their vaccination requirements. The Quality Manager and Executive Administration keep records of all staff vaccinations. There is an annual influenza program, and staff are vaccinated against Covid-19. DPH has a follow up process for those staff requiring immunisation or booster doses.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Comments
DPH has policies that are aligned with the Australian Guidelines for the Prevention and Control of Infections in Healthcare, including procedures consistent with jurisdictional requirements to prevent and manage infections such as novel infections to the workforce, patients and families. The policies include workforce screening, appropriate organisational charts to manage outbreaks, and exposure documents. DPH has processes to manage outbreaks and pandemics, with an active quality manager (Infection Prevention and Control portfolio) who works with the leadership team when required. The annual influenza vaccination program is in place, but the uptake is variable and not mandatory for clinical staff in the Northern Territory.

Rating	Applicable HSF IDs
Met	All

ACTION 3.17	
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.	
Comments	
DPH has undertaken a gap analysis, and all actions identified against AS 5369:2023 are in progress towards completion. In April 2024, DPH commissioned a new, fully compliant CSSD, reprocessing reusable medical devices via sterilisation. Management and staff involved in tracking reusable devices, cleaning processes, and cleaning of all endoscopes, confirmed relevant national standards are followed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.18	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement	
Comments	
DPH has an established antimicrobial stewardship program supported by evidence-based policies and procedures. The AMS committee reports to the Medical Advisory Committee, and the terms of reference include policy and procedure; providing access to evidence-based guidelines; antimicrobial formulary; restriction and approval process; review prescribing and surveillance data; reporting to clinicians regarding their data, and appropriateness of prescribing annualised NPAS and NAUSP data. Clinicians prescribing and administering antibiotics have access to Antibiotic Therapeutic Guidelines, with flowcharts describing roles and responsibilities, and access to restricted antimicrobials. DPH has access to advice from the Royal Darwin AMS pharmacists and AMS medical officer for advice and guidance regarding prescription of appropriate antimicrobials. The AMS Clinical Care Standard is used and continues to be a work in progress, while the latest audit results showed that 74% of antimicrobial prescriptions were in accordance with current therapeutic guidelines.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Comments
Documentation showed that the antimicrobial stewardship program includes the review of antimicrobial prescribing and the use of surveillance data on antimicrobial resistance. DPH use of antimicrobials is monitored via the National Antimicrobial Prescribing Survey (NAPS) and the National Surveillance Program (NAUSP). Recent NAPS data from October 2023 reflect a compliance rate of 60%. NAPS and NAUSP audit results are shared with clinicians, departments, and reported through to the governance structures. There is ongoing liaison with medical staff, encouraging prescribing within current evidence-based Australian Therapeutic Guidelines. A detailed gap analysis and work plan was sited using the HICMR template for the Antimicrobial Stewardship Clinical Care Standard.
Suggestion(s) for Improvement
Continue work with the medical staff regarding prescribing antimicrobials within the Therapeutic Guidelines, using the services at Royal Darwin Hospital, with advice from the AMS Pharmacist and AMS Medical Officer.

Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Comments
Medication management services are contracted from HPS Pharmacies (HPS) and are integrated into DPH systems for governance. The Medication Safety Committee reports to the Safety and Quality Committee, up to the Medical Advisory Committee. Healthscope and DPH policy, procedure, and consumer information to support standardised safe and effective medication management, are available on the HINT intranet and the L Drive. DPH's contract with HPS has identified KPIs, but these aren't always met. Consistent understanding of, and compliance with, key aspects of medication policy was noted among clinicians across the service. The medication chart is used and integrated into the medical record. Medication-related incidents are reported via the organisation-wide incident management system (RiskMan), and incidents and trends are reviewed by the Medication Safety Committee, used in education of nursing staff, and fed into improvement activities. Medication management training requirements are outlined in DPH training schedule, including medication safety and medication calculation competency. The medication competency rate across the service was 89 %.

Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Comments
A comprehensive suite of medication management audits includes a bedside audit, high risk medications and controlled drug audits, line labelling principles of safe selection and storage of medicines audit, S8, S4 and S11 compliance and clinical pharmacy interventions audit. The audits reflect the risks associated with medication management. Performance is reviewed by the Medication Safety Committee, and action is taken for continuous improvement. Action improvement plans are loaded into the eQUAMS (quality repository) for shared learnings across the organisation.

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	
The medication chart is integrated in the paper-based health care record, and 'pharmacy notes' that support safe administration of medicine was observed to be a high standard. The organisation is supported by pharmacists and pharmacy technicians.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Medication management discussions are conducted in partnership with patients and carers. Verbal and printed information is provided and patients and families are given a medication list when discharged from the facility. Interactions with patients were observed, with shared decision-making, and genuine engagement demonstrated across the service.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
Scope of practice relating to medication management is defined in position descriptions and in policy. APHRA registration, endorsements, notations, and specific requirements are monitored to inform on medication management permissions. DPH does not currently have any Nurse Practitioners.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
Comments
A best possible medication history (BPMH) is taken by medical officers, pharmacists, or nurses, as early as possible in an episode of care, and is informed by any additional sources of information such as the patient's family members and a current list of medications. The process for elective patients is that the BPMH is confirmed prior to, or on admission, where medications are reviewed and confirmed in the medication chart. The medication management plan is updated after reconciliation is completed and ordered by the medical officer as clinically appropriate. Compliance audits show that 91% of patients have a BPMH completed within 24 hours of admission. At DPH, medical staff document the medications in the paper-based chart. The pharmacist reviews the medications and performs the reconciliation.

Rating	Applicable HSF IDs
Met	All

ACTION 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Comments
A current patient's medication orders are reviewed against the best possible medication history and documented in the patient's medical record. Unexpected variation is investigated and actioned as required. Medication reconciliation occurs at admission, at transition of care, and at discharge to home.

Rating	Applicable HSF IDs
Met	All

ACTION 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
Comments
The process for identifying, documenting, and communicating allergies and reactions to medicines is well defined and monitored. The audit program demonstrated adequate compliance with policy for documenting and signing the allergies and adverse drug reaction in the front of the health record. The medication chart showed that documentation of adverse reactions during handover and medication administration was routine.

Rating	Applicable HSF IDs
Met	All

ACTION 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Comments
When a new adverse reaction to a medication is experienced in an episode of care, the patient's immediate clinical needs are met. The patient is informed of what has occurred and why, and family and carers are informed. The reaction is communicated to the appropriate clinical teams, and the reaction is recorded in the medical record. All incidents are recorded in RiskMan and reviewed by the Medication Safety Committee and Patient Care Review Committee. The patient is referred to the Royal Darwin Anaphylaxis Clinic for follow up. DPH has a strong culture of reporting incidents and near misses.

Rating	Applicable HSF IDs
Met	All

ACTION 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Comments
When a patient experiences a new adverse reaction to a medication during an episode of care, all reactions are reported to the TGA by the Nurse Unit Manager when required. The information is given to the patient and the patient's General Practitioner.

Rating	Applicable HSF IDs
Met	All

ACTION 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Comments
The indication for a medication review is evidenced-based and based on risk and clinical need. DPH is supported by pharmacists through the contract with HPS who are available for patients at high risk of harm. Medication reviews include monitoring therapeutic medication levels, reviewing current medications, and considering the cessation of the medication. Changes to medications following a medication review are documented in the paper-based drug chart and communicated to nursing staff,

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
patients, and carers. Evidence of medication reviews was observed, and responsible clinicians described the process, how it is documented, and action taken in response to a medication review.

Rating	Applicable HSF IDs
Met	All

ACTION 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Comments
A broad range of consumer medicines information is available and easily accessible on the DPH L Drive, including MIMS, handbook injectables, and therapeutic guidelines. Examples of consumer information such as managing pain and opioid medicines, anti-platelet and anti-coagulant medication, and eye drop information, was sighted. Pharmacists provide concise medicines information in a format that suits the needs of the patient and carers, and engagement with patients and carers regarding their individual needs and risks as part of the discussion about treatment options was observed.

Rating	Applicable HSF IDs
Met	All

ACTION 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes
Comments
Medications are discussed in the pre-admission process, nursing handover, CMO/VMO, interhospital transfer, and at discharge. A current list of medications, and any changes, is provided to all patients at discharge. HPS pharmacy dispenses discharge medications, or patients can take the discharge script to their local pharmacy. Performance is audited and compliance is in the upper percentile. Pharmacists and nurses were able to explain their role in clinical handover at discharge, including the medication discharge list.

Rating	Applicable HSF IDs
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
A broad range of references, resources, and decision-making tools for clinicians, was evident in both electronic and hard format, if required. Clinicians demonstrated their familiarity with the use of medication management support tools.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Comments	
DPH complies with manufacturers' directions, legislation and jurisdictional requirements for storage (including cold chain management), distribution and disposal of medications across the service. There is swipe access to medication storage for authorised staff to enter medication rooms. Unused or expired medications are managed well until their return to the pharmacy, where dedicated pharmaceutical waste bins are used for appropriate disposal. Corporate Healthscope and DPH medication policy has robust guidance for the management of S4 and S8 disposal processes. The cold chain process is managed well in the clinical areas via 'Soft Logic Invisible System' electronic monitoring system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Comments	
High risk medications are managed through an integrated system of policies, audits, education and tools. They are defined with the acronym APINCHS, and there is information regarding high-risk medications in procedures and education. Clinical staff demonstrated their familiarity with strategies for minimising harm from high-risk medications. High risk drugs are stored appropriately, with potassium stored in the 'after hours' locked cupboard and all anticoagulants stored in a separate drug cupboard, with drug type labelled in red. The use of TALLman lettering to distinguish between 'look alike' drug names was observed. There is an appropriate management system in place for the storage, dispensing and administration of these medications. Compliance with the independent double-checking process required for the administration of high-risk medications was observed. The S4 and S8 registers were checked during assessment, and very high compliance was noted.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Comments
DPH follows Healthscope policies in relation to Comprehensive Care planning, and these policies are readily available on the intranet for the clinicians. Clinical risks are identified through the Comprehensive Care Plan form completed on nursing admission and throughout the hospital stay as required. Any identified risks are entered on an alert sheet that is placed at the front of the patient's bedside chart and an alert is also entered onto the electronic patient journey board (WebPAS) screen. Strategies are in place to manage any identified risks, and there is an orientation process for new staff and ongoing monitoring of training requirements by the managers and through the e-learning system.

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Comments
DPH has a current Clinical Governance Plan developed with Healthscope which outlines the strategies and priorities for the delivery and monitoring of comprehensive care. Several quality projects have been developed in relation to comprehensive care, including falls management and delirium. Safety and quality reports are generated locally and disseminated to the governing body as well as consumers and staff. The results of reports in relation to falls, pressure injuries and medication errors are prominently displayed on the quality boards in the units, and these boards are visible to the patients, families and staff.

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
DPH has processes for partnering with patients in their care and associated decision-making to suit the patient. Staff described how they achieve this, and patients reported that they felt actively engaged in, and informed about, their care, with audit results confirming this. Bedside handover, Patient Care Boards and QR codes which linked to the Patient Information Directory engaged patients in their own care. Patients are asked if they have an Advance Care Directive and an alert is placed on their record and WebPAS journey board. On discharge patients can provide feedback either via email or through a paper-based form and the results from the surveys were mostly positive.

Rating	Applicable HSF IDs
Met	All

ACTION 5.04
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care
Comments
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. The organisation operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processed for referral where needed. There are close links with the Royal Darwin Hospital and escalation and referral pathways between the two facilities. Admission and Comprehensive Care procedures are in place identifying both patient needs and goals of care. These are included in the Comprehensive Care Plan with triggers for review and referral to other services as appropriate. DPH has systems in place to manage sepsis, palliative care and end-of-life care. Referrals from the ward areas to allied health clinicians are through the WebPAS system, this meets the needs of the organisation. The clinician with overall accountability is identified through the Patient Care Boards and on WebPAS.

Rating	Applicable HSF IDs
Met	All

ACTION 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Comments
DPH clinicians' roles are defined through position descriptions and there are strong professional links to RDH for the transfer of patients both in and out and of DPH and the process appeared seamless.

Rating	Applicable HSF IDs
Met	All

ACTION 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Comments
Clinicians and patients described how they work collaboratively to plan and deliver comprehensive care, and this was supported by observation of both Safety Huddles and Bedside Handover. The patient assessment and screening checklist assists in the decision-making for team members, with appropriate validated screening tools used to ensure comprehensive care is delivered. The Patient Care Board in place beside each bed identifies patients at high risk, those with allergies, their goals of care and shift team carer. The boards were observed being updated at handover, and Safety Huddles were also noted where patients at risk were discussed with all oncoming nursing staff and systems in place to mitigate the risk were identified. The paper medical record, Comprehensive Care Plans and WebPAS system are updated each shift and/or as required to keep clinicians informed.

Rating	Applicable HSF IDs
Met	All

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	
DPH use the Healthscope Comprehensive Care Plan Policy and Comprehensive Care Plan to provide integrated and timely screening, assessment and risk identification on admission and as required throughout the patient journey. Patients identified at risk have an alert sheet generated, that is placed at the front of the bedside notes and an alert is put into the electronic WebPAS board which is displayed at the Staff Base. If a patient is identified as having a risk through the screening process, they then have a more detailed assessment for that risk and interventions are put in place to help mitigate the risk. This is documented in the medical record. The comprehensive care plan was noted to be used in everyday practice, and multidisciplinary teams are involved in providing comprehensive care with processes in place to assist communication between team members.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
Patients are asked on admission if they identify as Aboriginal or Torres Strait Islander, and this is recorded in the medical record. Training is provided through Healthscope e-learning on 'Asking the question' and 'Cultural diversity and sensitivity in healthcare' to better meet the needs of Aboriginal and Torres Strait Islander people. The status reports for these courses showed good compliance with the training.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
The intent of this action is met. Patients are asked on admission if they have an advance care plan. This is then flagged in their medical record and an alert is placed on WebPAS and discussed at the Safety Huddles. Part of the process also allows patients to identify who they want to assist them in making decisions about their clinical care if they lack capacity.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
DPH use the Healthscope Comprehensive Risk Screening tool which is part of the Comprehensive Care Plan. The screening tools identify risks associated with cognitive impairment, medication management, malnutrition, falls, VTE, mental health, behavioural and substance withdrawal and pressure injury issues and risks of harm. Social and other circumstances are identified through assessment and integrated into the care planning process. Comprehensive Care, Comprehensive Care Mental Health, Clinical Risk Assessment and Observation Documentation are audited in line with the Healthscope auditing schedule. The results of these are monitored both by Healthscope and the DPH through the Comprehensive Care Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
Patients receive comprehensive assessment to determine their healthcare needs and appropriate treatment options on admission and throughout their hospital stay at DPH. Safety Huddles and Bedside Handover were observed and staff discussed the assessment and risk identification processes in place. When required referrals are made to other members of the care team such as physiotherapists, social work, speech pathology. Some of the services are provided through RDH but the systems in place for referral are robust and timely. Healthscope are currently trialling an Obstetric specific Comprehensive Care Plan which DPH are providing feedback on.

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
The intent of this action is met, as verified by the documentation in the Comprehensive Care Plan and the alert process in the paper medical record and on WebPAS.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Comments	
Clinicians use shared decision-making processes to develop person-centred and goal-directed comprehensive care plans that meet patients' identified needs. This was confirmed by a review of medical records and bedside Comprehensive Care Plans, and by observing bedside handover that involved the patient. Care is individualised depending on patient's needs, desires and risks and who they want involved with their care. Family meetings occur with the team when required to support shared decision-making. Referrals are made through WebPAS with some supporting services provided by RDH, and discharge planning commences at the beginning of the episode of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	
The comprehensive care plan directs the delivery of safe and effective care that aligns with the patient's needs and preferences, in partnership with the workforce and their families. The comprehensive care plan is monitored for effectiveness and updated as required throughout the patient's stay. Staff receive training in comprehensive care planning in orientation. Healthscope are currently trialling a new Obstetric Comprehensive Care Plan which DPH will provide feedback on.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
DPH have very few patients at the end-of-life. However, an End-of-Life box has been developed to assist staff looking after this cohort of patients. In the box is paperwork to assist the ward staff with documentation, as well as sensory tools including oil diffusers and music centres for the patients and family.	
Suggestion(s) for Improvement	
Given the limited number of patients cared for at end-of-life at DPH, resources from the Palliative Care Outcomes Collaboration (PCOC) may assist with this cohort of patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Comments	
RDH provides cover for palliative care services while the palliative care physician is on extended leave.	
Suggestion(s) for Improvement	
See Action 5.15 for a suggestion.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
DPH has processes to ensure that current advance care plans can be received from patients. Patients with advance care directives have this documented in their healthcare record and an alert is entered into WebPAS. The staff confirmed that plans get updated as requested by the patient.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
The workforce has access to supervision and support to alleviate workplace stress associated with delivering end-of-life care. The teams talked about debriefing sessions locally but also knew that they could access psychological support through a telephone Employee Assistance Program (EAP). The End-of-Life Care Box also provided some tools to support the workforce providing end-of-life care. Pastoral care is also available to support the workforce as well as the patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Comments
A limited number of patients are receiving end-of-life care at DPH, with one death recorded in 2023. However, the service has been reviewed and the End-of-Life Care Box implemented to support staff and patients with care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Comments
The intent of this action is met. Clinicians support patients, carers and families to make shared decisions about end-of-life care. Clinicians from various settings spoke about how end-of-life care is person-centred and includes family and carers. Decisions using advance care directives and electing not to be resuscitated are options available to patients and this was articulated by the clinicians spoken to.

Rating	Applicable HSF IDs
Met	All

ACTION 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Comments
The Healthscope - ‘Prevention, Identification and Management of Pressure Injury' policy is used by DPH, and management is guided by the National Pressure Injury Advisory Panel 2019 Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. Pressure injuries are monitored through RiskMan and the Comprehensive Care Committee at DPH, as well as Healthscope. There are few reports of hospital-acquired pressure injuries. Patients at risk of pressure injury, as identified by the Comprehensive Care Plan risk assessment tool, have a review by the physiotherapist and a plan put in place to aid mobility and reduce risk of PI developing. There has been recent purchase of air mattresses to assist in PI prevention.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Skin and pressure injury risk assessments (Waterlow) are undertaken as part of the Comprehensive Care risk screening on admission and throughout their hospital stay. Patients identified as having a pressure injury on admission or who develop an injury during their hospital stay have an incident report entered into RiskMan. These incidents are monitored by the Comprehensive Care Committee. There are devices that are available for patients at risk of developing pressure injuries such as air mattresses and strategies such as early mobilisation in place.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is available to patients, their carers and families about pressure injury prevention through Healthscope-designed pamphlets available in the wards and the Patient Information Directory available through a QR code on the Patient Information Board at the bedside. This information is in a user-friendly format and patients and staff described how they would use it. Equipment, products and devices, are available to prevent and manage pressure injuries. There is a referral process to the physiotherapists as required who work collaboratively on strategies to prevent pressure injuries with the patient, carer and nursing staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
DPH abides by Healthscope's evidence-based Falls Prevention and Management Policy. Patients are screened for risk of falls on admission and throughout their stay. Prevention strategies, harm minimisation and post-falls management occurs. Falls are monitored through RiskMan at DPH and by Healthscope KPIs. Patient involvement in falls prevention strategies is documented in the Comprehensive Care Plan. Patients at risk of falls or post-fall are discussed at the Safety Huddle handovers and appropriate documentation occurs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
DPH has equipment, devices and strategies to assist staff in preventing falls and minimising harm from falls. Training in falls prevention and management is provided to staff and patients by the Physiotherapy Department. A matrix for patient mobility and the type of equipment they require is being trialled and is a good initiative for staff to see the appropriate equipment for their patient at a glance. The team are currently investigating the use of video baby monitors for high risk falls patients. This project is in the preliminary stages and the team are gathering the evidence in relation to whether this will be a viable project for DPH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
There is information available to patients, their carers / families about falls prevention and risk management strategies both for hospital stay and for discharge and home care. This information is in a Healthscope information leaflet and available through the Patient Information Directory. The assessors witnessed the pamphlets and patients that were spoken to were aware of the information available to them.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
DPH has kitchens that prepare food onsite, and these were visited during the assessment with meal ordering and preparation discussed with the chefs. Patient are assessed on admission for nutritional needs using the malnutrition risk screening tool (MST) as well as any food allergies. Dietetic services are available to accept referrals for those patients who have special dietary requirements or where risk is identified. On admission patients can select their meals through a menu, allowing for dietary allergies or special dietary needs. Patient with food allergies identified through the Comprehensive Care Plan, have an alert placed on WebPAS. This can be seen by the team in the kitchens to ensure that meals are safe and acceptable for the patient. The kitchen has a rotating 14-day menu that has been developed with dietitians and has options for specific dietary requirements. Food is available after hours for patients who may have been fasting during the day. The Comprehensive Care Plan incorporates fluid balance monitoring while nutrition/hydration is assessed for whether the patient is independent, requires supervision or assisted meals. This information is then put on the Patient Care Board and was observed being discussed at bedside handover.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Comments
DPH provides nutritional support to patients based on specific needs identified through risk screening on admission. Food and fluid intake is monitored and reported for those patients who are at risk of not having their nutritional needs met, and the service has access to specialist dietetic support for those patients identified as being at risk or with specific needs. The WebPAS system highlights patients' dietary requirements/allergies in the kitchen where the individual meals are made. Fluid balance and nutrition/hydration is managed on the bedside charts. Staff were aware of who to assist with eating and drinking and encouraged families to visit during mealtimes to assist their family members to eat. Patients appeared to enjoy the meals they received, while kitchen staff reported that they get official feedback about the food but that patients will also write a note and place it on their meal tray with either a compliment or complaint.

Rating	Applicable HSF IDs
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
Patients are screened for delirium and cognitive impairment on admission and if clinically indicated during their admission. Evidence-based policies and procedures support staff in developing appropriate care plans and the strategies are reviewed for effectiveness. Patients identified at risk or who have delirium have an alert chart placed at the front of the bedside charts and an alert is placed on the WebPAS system, and are discussed at the safety huddles/bedside handover at the beginning of each shift, together with the strategies employed to manage the delirium disseminated to the next team caring for the patient. Distraction therapy was discussed and is being used for patients with cognitive impairment. Quality improvement in relation to cognitive impairment is currently being undertaken, including improving visibility for staff of high-risk patients and the development of a cognitive impairment consumer brochure. Both projects are yet to be evaluated.
Suggestion(s) for Improvement
Evaluation of the consumer brochure.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Comments	
Risk screening for cognitive impairment and delirium is undertaken) on admission and as required during admission using the Comprehensive Care Plan. If one or more risks factors are identified a complete cognitive assessment is undertaken. Staff were able to describe how they collaborate with patients, carers and families in individualising care for patients with cognitive impairment. A physical redesign of one of the ward areas is being undertaken to improve the visibility of patients at risk or with delirium.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Patients have a mental health risk assessment on admission to DPH, and patients at risk of self-harm have timely referral and access to psychiatry services. The Darwin Clinic provides support and voluntary admissions, and patients who require an involuntary admission are referred to RDH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
The Comprehensive Risk Screening tool includes a Mental Health Risk assessment, and referral and follow-up is timely and arrangements can be made through the Darwin Clinic (a voluntary mental health facility) within the campus or RDH if the patient is involuntary. Social work is provided through RDH. Staff were able to describe how they would access and use these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
DPH has policies in place that support the identification, mitigation and management of aggression, and patients are assessed as part of the comprehensive risk screening for behavioural/aggression risk on admission. This includes patients being asked about their use of alcohol, illicit drugs and tobacco, the withdrawal of which may trigger aggression. Patient, family and staff can raise concerns also through the risk screening process. Incidents in relation to aggression are entered and monitored through RiskMan and monitored by DPH Executive.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34		
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce		
Comments		
As noted above, the organisation has processes in place to identify patients at risk of becoming aggressive or violent. Staff complete mandatory training in WAVE 1 Managing Conflict and Challenging Behaviour with compliance reported to be over 90%. This program provides strategies in relation to de-escalation of aggressive or violent behaviour. Staff were aware how to escalate for assistance from other staff and when the assistance of police may be required. Duress alarms are in place throughout the organisation.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.35		
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body		
Comments		
Systems and policy are established to prevent harm if restraint is clinically necessary.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.36		
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body		
Comments		
The assessors verified this Action as not applicable.		
Rating	**Applicable HSF IDs**	
NA	All	**NA Comment:** Non-gazetted service, does not use seclusion. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
DPH has policies and procedures for safe clinical communication, with the ISOBAR tool used for clinical handover. Training for clinicians is conducted by educators and senior clinicians and this is monitored locally through the Director of Nursing. Clinical communication risks are understood, monitored and connect to the organisations risk management processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
There is evidence of audits being conducted and results being minuted at the Communicating for Safety Committee in relation to patient ID, patient health histories, nursing discharge summaries and alerts. These audits monitor the effectiveness of clinical communication and associated processes. Strategies to improve clinical communication were identified through the audit process. Incidents in relation to clinical communication are reported in RiskMan and monitored through the Communicating for Safety Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Interactions between DPH staff and patients were witnessed in which patients were verbally informed of, and were able to access, a Patient Information Directory through a QR code on the Patient Care Board for information relating to such things as falls and pressure injury prevention. Patients were positive about their experience at DPH and felt that they had been included in decisions about their care, and knew what was happening.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
There are Healthscope policies to support effective communication including 'Clinical Handover - Departmental and Intra-Unit'. Staff described the process in relation to clinical communication during an infusion procedure and at transfer of care in the operating theatres. Safety huddles and bedside handover were also observed during which risks and mitigating strategies were discussed. DPH take part in Healthscope audits of Operating Theatre Time-Out, Mental Health Time-Out, Clinical Handover and TMS Compliance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.05
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
Comments
DPH uses the approved identifiers of name, medical record number and date of birth. These are used on registration and admission, and when care, medication, therapy and other services are provided, as well as during clinical handover, transfer and in discharge documentation. Observations of bedside handover included efficient and complete confirmation of three approved identifiers, although there was variation when handover was undertaken in the Safety Huddles about the number of identifiers used. DPH audit results are tabled locally and through HSP committees and a suggestion has been made regarding the ongoing education and monitoring of clinical handovers.
Suggestion(s) for Improvement
Ongoing education, auditing and monitoring of clinical handovers and safety huddles should be used to ensure that clinicians use the three approved identifiers.

Rating	Applicable HSF IDs
Met	All

ACTION 6.06
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care
Comments
The use of approved patient identifiers for matching patients to their intended care was noted, and this included clinical handover, medication and blood product administration and time-out in operating theatres. Documentation in the patient history was completed appropriately, and audits are scheduled throughout the year through Healthscope.

Rating	Applicable HSF IDs
Met	All

ACTION 6.07
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover
Comments
Policies and procedures are in place to guide the communication of critical information at clinical handover. Safety huddles and clinical handovers occur across various care settings and are used to disseminate information to the team regarding patients at risk at each change of shift. . ISOBAR and three identifiers are used at bedside handover, while time-out was observed in operating theatres. Patients are involved in bedside handover and goals are identified and updated on their care boards. The completion of discharge summaries and other critical information is monitored and reported, and it was noted that there was sometimes a delay in the medical discharge summary being sent to the patients' general practitioners - this needs ongoing monitoring. A Clinical Emergency Response System is in place to support the escalation and communication of critical information in a timely way. The WebPAS system is a key tool which supports communication and captures risks and alerts, with functionality to make this available to those who need it at the appropriate time. Audits are conducted and reported to the HSP National Audit Schedule and reported at the Safety and Quality Committee meeting at DPH.

Rating	Applicable HSF IDs
Met	All

ACTION 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient’s goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
As noted above, DPH has policies and procedures to guide the communication of critical information at clinical handover. ISOBAR and three identifiers are used at bedside handover and when care is transferred between the team members. Patients are involved in bedside handover and goals are identified and updated on the care boards in the patient rooms. Handover of care in the ward setting is documented through the medical record and on the Patient Care Board at bedside handover.
Suggestion(s) for Improvement
Monitor completion and dissemination of the patient's medical discharge summary to general practitioners in an acceptable timeframe.

Rating	Applicable HSF IDs
Met	All

ACTION 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Comments
The intent of this action is met. Patients are assessed on admission using the Comprehensive Care Plan, which identifies patients at risk and triggers further assessment of the identified risk. Patients identified as being at risk then have an alert page entered at the front of the paper medical record and an alert is inserted into the electronic WebPAS patient board. The bedside Patient Care Boards are updated at each shift with patient and family wishes. Patients are involved in the bedside handover and the ISOBAR tool is used, and staff described how critical information is communicated and escalated. Staff were aware how to escalate care to other craft groups as required such as speech pathology or physiotherapy. Patients and carers can escalate care if they are concerned through the PACE system which has escalation instruction displayed on the Patient Care Board. Patients spoken to during the assessment were aware of this but had not had to use it.

Rating	Applicable HSF IDs
Met	All

ACTION 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Comments
Bedside handover occurs with patients and their carers and families during which concerns can be raised. The PACE system is in place which allows an independent escalation of care for patients, carers and families, with details displayed on the Care Boards at the bedside. The QR Code on the Care Board allows patients and families access to the Patient Information Directory which has multiple information sheets relevant to their admission.

Rating	Applicable HSF IDs
Met	All

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
Alerts and risks generated by the Comprehensive Care assessment are documented in the medical record and an alert document is placed prominently in the bedside documents. Alerts are then entered into the WebPAS system and on the bedside Patient Care Board, while care plans are updated at least daily, or more often if required. Patients with medication allergies will also have alert arm bands and the same documented on the medication chart. A comprehensive audit schedule is in place that includes a range of audits related to documentation with links to the governance structure for reporting and monitoring.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
DPH has policies and procedures to support blood management and associated risk. Governance is through the Blood Management Committee which is supported by Healthscope's National Blood Safety Committee which monitors any adverse events. There is mandatory Blood Safety training for staff administering blood and blood products.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	
The Blood Management Committee oversees the use of blood products and a quality improvement project has seen a marked reduction in the wastage of blood products. There is minimal use of blood products and no sentinel events reported in the last 12 months.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Patients are actively involved in their care in relation to safe blood management, with consent sought prior to the administration of blood products. There are policies in relation to patients who may decline transfusions for religious or other reasons. Patients are surveyed post transfusion either in person or via email for feedback.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.04	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
One patient was observed receiving plasma during the assessment. DPH has adopted the single unit policy which minimises the use of blood products. Patients are screened by the treating medical officer pre-admission and patients at risk of large blood loss are managed through RDH. RDH pathology also has Rotational Thromboelastometry (ROTEM) available for patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
The transfusion of blood products observed during the assessment had the correct documentation in the patient's medical record.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
DPH has policies supporting clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
Any adverse events are entered into the RiskMan incident management system and reviewed at the Blood Management Committee. There have been no reported transfusion-related events in more than twelve months.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
The Blood Management Committee oversees haemovigilance activities, based on the National Framework.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
There is one blood refrigerator located in the operating theatre suite which holds two units of O negative blood. This refrigerator is monitored, and the blood stock rotated and monitored by the Pathology Department of RDH.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
There is minimal use of blood and blood products at DPH. The only blood kept at DPH is two units of O negative blood in the theatre complex. Pathology services from RDH manage the blood refrigerator and rotate the two units of O negative blood to reduce wastage. DPH use the one-unit policy. Patients requiring a large volume of blood would be transferred to RDH. Wastage is also monitored through Blood Management Committee and a project has been in place to reduce waste with significant associated savings.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
DPH has several policies and procedures for recognising and responding to acute deterioration, which reference the National Consensus Statement for acute and mental health deterioration, and the National Clinical Delirium Clinical Care Standard. DPH Patient and Carer Escalation of Care (PACE) are in place and accessible on the local L-Drive, and available on patient care boards. Risks are identified through the risk management system (RiskMan) and patient feedback. The Clinical Deterioration Working Group review all RiskMan incidents and policies related specifically to DPH. Training needs for this standard include BLS, ALS, PALS and Neonatal Resuscitation. Compliance for training was within, or close to, Healthscope's benchmark. Staff were able to describe their role, and there are clear flow charts describing roles and responsibilities in relation to responding to acute deterioration.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
The effectiveness of processes for managing and identifying acute deterioration is monitored, and this is reported through the Patient Care Review Committee and Medical Advisory Committee to clinicians for the purpose of clinical review. All incidents are recorded in the incident management system (RiskMan), and there appears to be a good reporting culture. There are several audits in place, including Observation Chart Audit, emergency trolley checklist and escalation of care, which are all within Healthscope's KPI parameters.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Documents showed that there is a process in place to support partnering with consumers in recognising and responding to acute deterioration. DPH has a procedure for Patient and Carer Escalation of Care (PACE) and all PACE calls go directly to the Director of Nursing or After-Hours Coordinator. Clinical review, clinical handover and PACE calls all involve patients and families, meeting their individual needs and shared decision-making. In the last six months eight incidents were recorded in RiskMan related to PACE calls. These were all attended by a clinical review, and action taken as required. Staff and patients confirmed that patients are actively involved in planning and making decisions about management of acute deterioration. Clinicians and patients described examples of shared decision-making.

Rating	Applicable HSF IDs
Met	All

ACTION 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
Comments
Adult observation charts are in place for adults, and age-appropriate observation charts for paediatric and newborns, to document and monitor vital signs graphically over time. Modifications for individual patients are used when required, and there is of escalation of care when vital signs were outside normal parameters. The care plan also provided evidence of individual monitoring. Adequate monitoring equipment for patient observations was noted.

Rating	Applicable HSF IDs
Met	All

ACTION 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
DPH policies and procedures support staff in identifying acute mental state deterioration, including the risk of delirium, and patients are screened for mental health issues on admission. Staff in clinical areas described where to access the procedure and policy, and when to escalate their concerns. DPH has a range of tools to assist staff (e.g. Comprehensive Risk Screening Tool, Behavioural Charts, Purposeful Rounding Tools, Alcohol Withdrawal Charts, Edinburgh Post Natal Depression Chart, Inpatient Specialising Care Assessment tool). The 4AT Assessment tool is used for Delirium and Cognitive Impairment, while the Delirium screen pathway/flowchart can be used to guide care for patients with suspected Delirium. Assessment and care planning documentation shows that assessment drives the establishment of individualised and appropriate management plans for acute mental health deterioration and/or delirium. Clinical documentation is audited quarterly. Processes are in place to support timely communication between members of the treating team, patients, carers, and family members.

Rating	Applicable HSF IDs
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
DPH monitors the identification and management of acute physiological and mental status deterioration, and pain and/or distress, and concerns raised by staff, patients, carers, and families, through clinical documentation audits, incident management, and clinical review. Risks are identified through the incident management system (RiskMan), patient feedback, and PACE. All incidents are reviewed by the Clinical Deterioration Working Group, which report to the Patient Care Review Committee and to the Medical Advisory Committee. Staff and patients were aware of these processes and described them, including processes for escalation of care when required. Documentation, identified that corporate and local policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration, and they are current and reference best practice.

Rating	Applicable HSF IDs
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers, and families, to directly escalate care. DPH uses a Patient and Carer Escalation of Care (PACE) for family and patient escalation. PACE posters, and information on the patient care board at individual patient bedside, were evident throughout the facility.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The process for escalating care is clear and outlines the responsibilities and direction for staff to escalate care and respond to a clinical emergency. Emergency call bells, 24hr medical coverage, and rapid response teams are in place to support the escalation of care. DPH has systems in place to call Code Blue teams from Royal Darwin Hospital to respond to, and support, escalation of care. Staff described the processes, and there is documentation to support the evaluation of these processes, which are reported through the Clinical Deterioration working group, Patient Care Review Committee and the Medical Advisory Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Corporate Healthscope and DPH policies for the escalation of care are clear and precise and provide direction for staff to escalate care and respond to a clinical emergency. Staff described this process and the assessors were provided with documentation to support the evaluation of these processes, which are reported through to the Clinical Deterioration working group and Patient Care Review Committee. All clinical reviews and Code Blue Calls are reviewed at the Medical Advisory Committee and relevant craft group meetings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
DPH provides education to clinicians to support timely and effective management of patients who have acutely deteriorated. Compliance with BLS, ALS, PALS and Neonatal resuscitation for appropriate staff was in the high percentile. DPH runs mock scenarios to ensure staff keep up to date with their skills required for patient deterioration.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency. Specialised areas such as Operating Theatre, and RMOs, Nurse Unit Managers and After-Hours Coordinators, ensure that there is 24/7 coverage by clinicians who can deliver advanced life support. The organisation is also supported by the Royal Darwin Hospital, providing care for Code Blue situations (covering adult, mental health deterioration, paediatric, and obstetrics).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Clinicians confirmed the process for timely referral to mental health services, to ensure that these referrals meet the needs of patients whose mental state has acutely deteriorated. DPH has access to the Royal Darwin Hospital for patients whose mental health has deteriorated, by calling 000 and rapid referral to the emergency department at the Royal Darwin Hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for timely referral to deliver care for patients who physically deteriorate. Staff described these processes, and the effectiveness of care processes is monitored through the clinical deterioration working group, Patient Care Review Committee and the Medical Advisory Committee.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil.