NSQHS Standards 2nd Edition Assessment Healthscope - Hobart Private Hospital 101240

Accreditation Status	*Accredited*
Date(s) of Assessment	*05/03/2024 - 08/03/2024 (Initial)* *07/06/2024 - 07/06/2024 (Final)*
Site	*Corner Argyle and Collins Street Hobart TAS 7000*
Scope of certification	*Provision of a range of services inclusive of Medical, Surgical, Obstetric, Cardiology including an Emergency Department. Paediatric >2 years.*

Details and Registration of the Health Service
Tasmania Government Licence No PH I998-01-01-05 *Radiation Licence L001285 dated 4/09/2023*

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

Contents

ABOUT THE COMMISSION

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

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

THE AHSSQA SCHEME

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

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

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

RATING SCALE DEFINITION

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

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

Suggestions for Improvement

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

ACCREDITING AGENCY

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

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

Conflicts of Interest

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

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

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

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Hobart Private Hospital
The outcome for this assessment is	Accredited
Date of accrediting agency determination	28/06/2024
Date health service organisation notified	28/06/2024
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

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

5.36

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

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

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	Yes Sampling included Critical System Review RiskMan ID 346438
Has there been any inspections/audits by regulators?	Yes Food Business Inspection Report 30/02/2024 Private Hospitals Maternity Care Audit 14/05/24 – with 11 recommendation identified with the HSO given a time frame of 19/08/2024 to action the report. HPH Private Hospitals Child Patient Audit 2024 23/04/2024 with four recommendations identified with a time frame of 31/07/2024 set.

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Initial assessment it was noted that the previous certifying body certificate was on display with an updated certificate requested.	Yes

Requirement	Assessment Outcome	Complies
	Final Assessment evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements.	
Patient Episode	During the assessment the assessment team had the opportunity to visit and spend time in the clinical area observing various aspects of patient care and held discussions with the clinical staff regarding the NSQHSS. - Clinical Handover from night-duty to morning staff on the surgical ward MRN #201987; #198313; #121895; #375524; #957805; #388841 and #364678. - Administration of regular oral medication MRN #307507 - Schedule 8 medication administration by two Registered Nurses MRN #919522 and #917350 - Checking Patient Controlled Analgesia settings against the PCA order MRN #121895 and MRN #375524 - Checking, labelling, patient identification process, presence of allergy and administration of intravenous antibiotics MRN #337919 - Checking and administration of high risk medication MRN #3379191 - Whilst the assessor was reviewing clinical process on the Surgical Ward a Met Call was activated for a Patient experiencing chest pain which demonstrated embedded processes in the management of the deteriorating patient. RiskMan ID 2123346 - Theatre Suite including Day Surgery Unit (DSU) and Endoscopy Suite – pre-admission of a patient UR #175400, administration admission of patient UR #332759, nursing admission of patient UR #332759 and UR #947087, anaesthetic nurse check pre operative UR #375383, team “time out” UR #375887 and UR #328423 , stage 1 recovery care, clinical handover from anaesthetist and nursing staff from theatre to stage 1 recovery UR #921322 and UR #915737, clinical handover from recovery room nurse to inpatient ward, clinical handover from stage 1 recovery to stage 2 recovery UR #978379 and UR #186448, post procedure review by Gastroenterologist UR #186448, patient identification and medication administration. Bedside handover from ND staff to AM Staff on the medical ward for the following patients UR #970201, UR #375975, UR #375196, UR #107866, UR #961275, UR #375957, UR #181410, UR #302486 and UR #951584. Bedside handover from AM Staff to PM Staff for the following patients UR #373370, UR #374421 and UR #373147. Observation of the patient episodes of care enabled the assessors to verify that processes have been introduced for the requirements of NSQHSS edition 2 including (but not limited to) infection prevention and control practices; medication safety and administration; comprehensive care risk assessments, alerts and	Yes

Requirement	Assessment Outcome	Complies
	management; clinical communication including huddles, handover, patient identification and procedure matching; blood management processes; patient deterioration including emergency equipment and escalation. The assessors also observed patient related processes including: - Reprocessing of reusable medical devices including CSSD and Endoscopy. - Infection prevention and control processes and procedures A sample of medical records were also reviewed to further verify documentation of processes including clinical assessment prior to admission these include UR #182713, UR #351453, UR #375794, UR #375817, UR #198512, UR #306349, UR #302486, UR #201196 and UR #951584.	
Consumer Interview	During the assessment, the assessors had an opportunity to speak with a number of patients during visits to the departments including an interview with two patients (UR #375388 and UR #927065). Both patients felt well informed, had opportunities to ask questions and were very happy with the care they had received. There was also an opportunity to discuss the orientation process with the newly appointed Volunteer Consumer Consultant.	Yes

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Melissa Clune (National QA Improvement Manager) Initial and Final	Yes	No
Kathryn Berry (General Manager) Initial and Final	Yes	Yes
Alvin Cheam (Director of Nursing) Initial and Final	Yes	Yes
Serusha Solomon (Quality Manager) Initial and Final	Yes	Yes
Dana Rowe (Global-Mark Assessor) Initial and Final	Yes	Yes
Shelley Bustos (Global-Mark Assessor) Initial and Final	Yes	Yes
Ann Knight (National Accreditation Manager) Initial only	No	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	- Management of patient deterioration - Bariatric patient management

	- Paediatric patient management - Medication incidents - Management of falls

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO: - Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	Located adjacent to the Royal Hobart Hospital. There is a co-located pharmacy. Hobart Private Hospital is owned and operated by Healthscope which provides enormous corporate support including corporate policies and documents, IT support, incident reporting mechanisms (RiskMan), patient feedback mechanisms, credentialling processes (cGov) and provision of the eLearning platform. Co-located services include radiology, pathology and pharmacy.
List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of: - Sterilising - Laundry services - Food preparation - Theatre Services	Biomedical equipment- Chemtronics Linen Clinical waste

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

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Dana Rowe	A1074	Yes
Auditor	Shelley Bustos	A1923	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

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

Executive Summary

The Hobart Private Hospital is a 146 bed private hospital with five operating theatres including a cardiac catheterisation laboratory with first and second stage recovery areas. Wards includes obstetrics, medical and surgical services. Paediatrics admissions for 2 years and above are accepted. Hobart Private Hospital also has a 24 hour emergency department. St Helen's Private Hospital (SHPH) which up until its closure in June 2023 was part of the HPH. Licenced by Department of Health and Human Services Tasmania.
Located adjacent to the Royal Hobart Hospital. It is owned and operated by Healthscope one of Australia's leading providers of hospitals, medical and pathology centres. Healthscope provides enormous corporate support including corporate policies, personnel and documents, IT support, incident reporting mechanisms (RiskMan), patient feedback mechanism, credentialling processes (cGov) and provision of an eLearning platform.
Three findings from the previous assessment were addressed and sufficient evidence was sighted to rate the action items as met. A number of criteria were rated as "Met with Recommendations" at the initial assessment with the facility given the allocated 60 business days before an on site final assessment was undertaken on 07/06/2024, with the evidence sighted the Assessor was able to close out a number of the findings with twelve Met with Recommendations remaining. Although there is evidence of significant progress, the processes have not yet been fully implemented or monitored. The Assessors acknowledge the efforts of the Management supported by the corporate team, which has resulted in the positive outcome of the final assessment.

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

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.01	Action not fully implemented	Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data. MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation.	Met with Recommendations
1.03	Action not fully implemented	Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data. MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation.	
1.05	Action not fully implemented	Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation.	
1.07	Action not fully implemented	The effectiveness of the Quality Plan resulting from non-compliant audits is unclear. Example - Quality Plans progress for the surgical floor Medication Fridge Temperature and the Resus Trolley has been ineffective with compliance remaining below the benchmark. Ensuring that all documents utilised by the workforce are appropriately controlled will ensure that the correct version of a document is available to the workforce. Noted that the Post natal care plan is not document controlled including nil Medical Record Number identification	Met with Recommendations
1.08	Action not fully implemented	The process to involve consumers in the review of safety and quality performance and systems is not fully implemented.	Met with Recommendations
1.09	Action not fully implemented	Although there is an extensive committee structure in place at Hobart Private Hospital with reporting evident, the process to ensure that	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		timely reports are provided to the relevant committees is not fully implemented.	
1.10	Action not fully implemented	Reporting on risks to consumers is not fully implemented.	Met with Recommendations
1.11	Action not fully implemented	The process to ensure that consumers are involved in the review of incidents and the provision of feedback on the analysis of incidents to the consumers is not fully implemented.	Met with Recommendations
1.12	Action not fully implemented	Although there is an open disclosure policy - 2.30 Open Disclosure 10/23 in place – documentation of the open disclosure process has not occurred in the following medical records reviewed MRN # 134535, MRN # 912082 and MRN 141353, despite been flagged through RiskMan as occurred.	Met with Recommendations
1.14	Action not fully implemented	The process to ensure that consumers are involved in the review of complaints and the provision of feedback on the analysis of complaints to the consumers is not fully implemented.	Met with Recommendations
1.20	Action not fully implemented	Although the training requirements for VMOs have been identified and management are in the process of capturing this information, along with a Mandatory Training program in place for employed staff, on review of the training completion rates there were identified gaps (Medsafe 30% ALS 46% Resus4kids 35%) which will be assessed at the final assessment. Noted that a training day is scheduled for 28th March which will assist with compliance.	Met with Recommendations
1.22	Action not fully implemented	Processes to ensure that the members of the workforce regularly take part in a performance review is not fully implemented. Performance review completion rate is 50.5%.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
2.01	Action not fully implemented	Implementing policies and procedures for partnering with consumers at Hobart Private Hospital is not fully undertaken.	Met with Recommendations
2.02	Action not fully implemented	As processes for partnering with consumers is yet to be fully implemented, monitoring and reporting on partnering with consumers is also not fully implemented.	Met with Recommendations
2.06	Action not fully implemented	Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care.	Met with Recommendations
2.09	Action not fully implemented	Corporate policies on consumer participation include how information is reviewed by consumers, families and their carers. Local consumers have been involved in the past in the review of patient information, however this has not occurred for some time. Processes will recommence once the Consumer Engagement Committee has occurred.	Met with Recommendations
2.11	Action not fully implemented	Processes to involve consumers in partnerships in the governance of, and to design, measure and evaluate, health care is not yet fully implemented.	Met with Recommendations
3.03	Action not fully implemented	Reporting processes for AMS outcomes to patients/consumers is not fully implemented.	Met with Recommendations
3.05	Action not fully implemented	Reporting processes for AMS outcomes to patients/consumers is not fully implemented.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
3.15	Action not fully implemented	The risk-based workforce vaccine-preventable disease screening and immunisation program consistent with the current edition of the Australian Immunisation Handbook for VMOs has yet to be fully implemented.	Met with Recommendations
4.02	Action not fully implemented	The facility has implemented the NIMC and its use is well embedded, however, the introduction of the paediatric NIMC has yet to occur. During the assessment it was identified that a VMO is utilising a stamp to facilitate the prescribing of their medications. MRN # 307507	Met with Recommendations
4.14	Action not monitored/reviewed	Monitoring the process utilised to discard unused scheduled drugs in the operating theatre is not fully implemented.	Met with Recommendations
5.10	Action not fully implemented	Although the Comprehensive Risk Screening Form (HMR 6.13) is utilised for screening processes, this is yet to be implemented on the Maternity ward.	Met with Recommendations
5.13	Action not fully implemented	Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care.	Met with Recommendations
5.14	Action not fully implemented	Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		plans sighted in the medical records have no provision to document goals of care.	
5.19	Action not fully implemented	The processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care is not fully implemented.	Met with Recommendations
6.05	Action not fully implemented	In the small sample of medical records sighted during the review, a number of records did not contain the patient's three identifiers. Examples include: Consent for medical and/or surgical treatment with doctors own labels were noted. Registration Forms missing the three identifiers.	Met with Recommendations
6.06	Action not fully implemented	Although there is a Theatre Time Out Audit scheduled on the National Audit Schedule, with results noted to be consistently high (97% 2022 and (5% in 2023), inclusion of all team members in the "TimeOut" procedures observed by the assessors was not fully implemented. During the review of Medical Record UR #182713 it was also noted that nil documentation that time out has occurred. The inclusion of the software utilised in the endoscopy suite in the time out process would strengthen this procedure.	Met with Recommendations
6.08	Action not fully implemented	Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care.	Met with Recommendations
7.03	Action not fully implemented	In the small sample of medical records sighted during the review, processes to ensure consistent use of the Blood Consent is not fully implemented.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
8.04	Action not fully implemented	The process of graphically documenting and tracking changes on the observation chart is not fully implemented.	Met with Recommendations

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.07	Action not fully implemented	Evidence sighted at the final assessment that the Health Information Team have reviewed each clinical area ensuring the correct HMR documentation is available and refined the process for archiving old, removing out of date documentation and replacing current HMR documentation. There is a standing agenda item on the Quality and Clinical Governance Committee for on-going review and implementation. Spot audits are undertaken – sighted spot audit undertaken by the Health Information Manager (HIM) and the Quality Manager 5/24 Discussions with the DON confirmed that this is a discussion item that is undertaken at the DON/NUM bed meeting also. Huddle Meeting DON/NUM 06/06/24 NUM/DON Meeting Allied Health 05/02/24 Although there has been considerable progress in ensuring that all documents utilised by the workforce are appropriately controlled this will remain a met with recommendations as is yet to be fully implemented.	Met with Recommendations
1.12	Action not fully implemented	During the final assessment a review of the following medical records with evidence that open disclosure was undertaken, however the level of documentation is not is not consistent with the policy 2.30 Open Disclosure 10/23 . URN # 376000 incident ID 2124596 URN # 340463 incident ID 2131470	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		A met with recommendation will remain and will be reviewed further at the mandatory reassessment.	
1.20	Action not fully implemented	Evidence sighted that management continue to implement the training program with compliance rates as of 20/05/24 BLS 72% ALS 44% Resus4Kids 46% and Manual Handling 76% MedSafe 56%. Management continue to capture VMO training continues, the process is yet to be fully implemented.	Met with Recommendations
1.22	Action not fully implemented	Evidence sighted at the final assessment that management now utilise the Dimensions platform to capture performance appraisal compliance with Department Managers plan and schedule appraisals dates. Reporting compliance occurs at the NUM/DON meeting and the Quality and Clinical Governance Committee. Current appraisal completion rate 75% Huddle Meeting DON/NUM 06/06/24 NUM/DON Meeting Allied Health 05/02/24 A met with recommendation will remain and will be reviewed further at the mandatory reassessment.	Met with Recommendations
2.06	Action not fully implemented	Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
		Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.	
3.15	Action not fully implemented	Evidence sighted at the final assessment that progress has been made in the capturing of the immunisations information for the VMO, but not yet fully implemented. A VMO training and immunisation spreadsheet has been implement to assist with monitoring.	Met with Recommendations
4.02	Action not fully implemented	Although the use of the paediatric NIMC was tabled at the National Paediatric Committee for Healthscope, it was determined that it will not implemented at HPH. Processes have been established to ensure safe medication management for paediatric patients, including recording of patient weight on all NIMC and a Paediatric/Neonatal Prescription form protocol that needs to accompany all NIMC. Therefore, there is sufficient evidence for this action to remain as a Met with Recommendations and not escalate, however these processes are not fully implemented.	Met with Recommendations
5.13	Action not fully implemented	Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.	Met with Recommendations

Action	Gaps in implementation identified	Recommendation(s)	Rating
5.14	Action not fully implemented	Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.	Met with Recommendations
6.08	Action not fully implemented	Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.	Met with Recommendations
7.03	Action not fully implemented	Although an immense amount of education, communication and auditing was evidenced at the final assessment regarding the processes for ensuring correct documentation is completed regarding blood and blood products, the sample of medical records reviewed by the assessment team verified that these processes are not yet fully implemented.	Met with Recommendations
8.04	Action not fully implemented	Although there was evidence of education, communication and auditing around the appropriate graphical documentation of observations (including joining the dots) and an improvement was noted by the assessment team, this process is not yet fully implemented.	Met with Recommendations

DETAILED REPORT FOR STANDARDS ASSESSED

Action 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance
Evidence Reviewed
Initial Assessment: Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data. MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation. Records and documents sighted during the assessment Quality Activity eQuaMS ID:13052 Local Government Committee Structure - Revision and Implementation 2024 Organisational Structure 2024 Onsite Committee Reporting Flowchart 2024 HPH Education Plan inclusive of a Training Needs Analysis Radiation Licence L001285 dated 4/09/2023 4.36 Police/Clearance and Working with Children Checks 7/22 Risk Register

ACHS Clinical Indicator 2H 2022 , 1H 2023
2.30 Open Disclosure 10/23
Tasmania Government Licence No PH I998-01-01-05
Quality and Safety Boards displaying data displayed in the Clinical Areas
2024 HPH Education Plan includes a Training Needs Analysis
2.17 Consent to Medical/Surgical Treatment 12/22
Healthscope Limited Bylaws 7/18
Healthscope Aboriginal and Torres Strait Islander Reconciliation Action Plan Jan 2024- Dec 2025
1.08 Exclusion Criteria, Hobart Private Hospital 12/21
Medication Safety Committee 5/09/2023
Medication Safety Committee Terms of Reference 2023
Staff Development Unit - 2024 Education Plan
Staff Development Unit 2-23-2024 Training Records
HPH Mortality and Morbidity Committee Review 2024
Maternity and Paediatric Services Committee 23/02/2023 and 4/05/2023
Bariatric Manual Handling Working Group 27/03/2023
WHS Committee Meeting Minutes 13/12/2023
HPH Disaster and Emergency Plan 2024

Final Assessment: Evidence sighted at the final assessment that HPH has reviewed and implemented a Committee Structure which identifies the structure of reporting lines and the highest level of governance committee. Committee Meeting Schedule 2024 with associated guidelines in place.

All Committee have documented Terms of Reference (TOR) which outlines their scope and purpose, function, membership, quorum, reporting lines, frequency and review. All Committee agendas have been reviewed with agenda items for each Committee based on the confirmed TOR. The HPH meeting schedule has been revised based on committee structure and TOR to clearly identify meeting frequency and membership. Department representatives to the relevant committee have been identified.

Management are planning to evaluate the committee structure with mid and end of the year evaluations planned.

Minutes sighted:

Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024
MAC Minutes of Meeting 27/03/2024
MAC Minutes in draft 29/05/2024
Quality and Clinical Governance Committee TOR 2024
MAC Terms of Reference 7/23

Hospital Executive Meeting Terms of Reference 3/24

Rating

Met

Findings

-

Action 1.02

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

Evidence Reviewed

Corporate documents include The Healthscope Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan Jan 2024- Dec 2025, this documents sets out the framework to develop relationships with Aboriginal and Torres Strait Islander Communities.

There is an Acknowledgement of Country policy in place 1.03 dated 02/22 with acknowledgement of Country conducted at the commencement of each committee meeting.

Artwork is displayed in public spaces together with a short bio on the painter. Acknowledgement of country signage is displayed in the public areas.

The Quality Manager has availed of opportunities to engage with local communities which include visits to Risdon Cove with invitations extended to this community to visit the hospital, a visit to the Royal Hobart Hospital to build relationships with the ALO, engagement with a local ATSI Teacher with whom engagement activities were shared, attendance at a Smoking Ceremony at the Community Centre.

In the maternity unit books on Maternity by an ATSI Author were given to parents as a gift.

Management have identified workforce members who identify as ATSI who could be consulted if required.

Information brochures are available which included Aboriginal Health Services Information Sheet.

Training in "Cultural Diversity and Sensitivity in Healthcare" is undertaken by the workforce.

Celebration of NAIDOC week in July 2023 was undertaken.

Ensuring all ATSI engagement activities are formally documented will guarantee evidence for compliance is available.

Rating

Met

Findings

-

Action 1.03
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
Evidence Reviewed
Initial Assessment: Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data. MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation. Final Assessment: Evidence sighted at the final assessment that HPH has reviewed and implemented a Committee Structure which identifies the structure of reporting lines and the highest level of governance committee. Committee Meeting Schedule 2024 with associated guidelines in place. All Committee have documented Terms of Reference (TOR) which outlines their scope and purpose, function, membership, quorum, reporting lines, frequency and review. All Committee agendas have been reviewed with agenda items for each Committee based on the confirmed TOR. The HPH meeting schedule has been revised based on committee structure and TOR to clearly identify meeting frequency and membership. Department representatives to the relevant committee have been identified. Management are planning to evaluate the committee structure with mid and end of the year evaluations planned. Minutes sighted: Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024 MAC Minutes of Meeting 27/03/2024 MAC Minutes in draft 29/05/2024 Quality and Clinical Governance Committee TOR 2024 MAC Terms of Reference 7/23 Hospital Executive Meeting Terms of Reference 3/24

Rating
Met
Findings
-

Action 1.04
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
Evidence Reviewed
Corporate documents include The Healthscope Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan Jan 2024- Dec 2025, this documents sets out the framework to develop relationships with Aboriginal and Torres Strait Islander Communities. There is an Acknowledgement of Country policy in place 1.03 dated 02/22 with acknowledgement of Country conducted at the commencement of each committee meeting. Artwork is displayed in public spaces together with a short bio on the painter. Acknowledgement of country signage is displayed in the public areas. The Quality Manager has availed of opportunities to engage with local communities which include visits to Risdon Cove with invitations extended to this community to visit the hospital, a visit to the Royal Hobart Hospital to build relationships with the ALO, engagement with a local ATSI Teacher with whom engagement activities were shared, attendance at a Smoking Ceremony at the Community Centre. In the maternity unit books on Maternity by an ATSI Author were given to parents as a gift. Management have identified workforce members who identify as ATSI who could be consulted if required. Information brochures are available which included Aboriginal Health Services Information Sheet. Training in "Cultural Diversity and Sensitivity in Healthcare" is undertaken by the workforce. Celebration of NAIDOC week in July 2023 was undertaken.
Rating
Met
Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
Initial Assessment: Hobart Private Hospital has an extensive committee structure in place with reporting of safety and quality data evident. On review of the Committee schedule 2023 which included reporting lines, the 2024 Onsite Committee reporting flowchart and the various TOR it was unclear to the assessment team which committee is responsible for the implementation and management of Clinical Governance with meeting minutes sighted for both committees. Minutes reflected an inconsistent reporting pattern of safety and quality data. MAC minutes sighted 7/12/2023 and 13/09/2023. Quality and Risk Meeting minutes sighted 19/10/2023, 07/09/2023 and 13/02/2023. During the assessment the assessors were presented with new documentation which included a Quality and Clinical Governance Committee Terms of Reference 2024 along with a Quality and Clinical Governance Committee Agenda and a Quality and Clinical Governance Committee Minutes template. The Committee with new agenda is to be implemented and will be reviewed at the final assessment. Quality Activity eQuaMS ID: 13052 Local Government Committee Structure - Revision and Implementation. Final Assessment: Evidence sighted at the final assessment that HPH has reviewed and implemented a Committee Structure which identifies the structure of reporting lines and the highest level of governance committee. Committee Meeting Schedule 2024 with associated guidelines in place. All Committee have documented Terms of Reference (TOR) which outlines their scope and purpose, function, membership, quorum, reporting lines, frequency and review. All Committee agendas have been reviewed with agenda items for each Committee based on the confirmed TOR. The HPH meeting schedule has been revised based on committee structure and TOR to clearly identify meeting frequency and membership. Department representatives to the relevant committee have been identified. Management are planning to evaluate the committee structure with mid and end of the year evaluations planned. Minutes sighted: Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024 MAC Minutes of Meeting 27/03/2024 MAC Minutes in draft 29/05/2024 Quality and Clinical Governance Committee TOR 2024 MAC Terms of Reference 7/23 Hospital Executive Meeting Terms of Reference 3/24
Rating
Met

Findings
-

Action 1.06
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients
Evidence Reviewed
Roles and responsibilities of the Organisation is articulated in the Corporate Clinical Governance Framework and the Healthscope By Laws. Each member of the workforce is provided with a position description which outlines their responsibilities, accountabilities, scope of practice, and safety and quality requirements, which is discussed and reinforced with each member of the workforce during their performance appraisal. Performance and Development Form 11/21 prompts a review of the position description at this time. Position descriptions sighted include: Nurse Educator /Clinical Nurse Educator 3/22 Instrument technician 3/22 Food Services Technician 3/22 Assistant in Nursing 2/22 An opportunity for improvement was raised as the Working with Vulnerable people (WWVP) checks are currently being undertaken and monitored by the NUMS- a more centralised approach would assist with this monitoring process. The corporate policy 4.36 Police/Clearance and Working with Children Checks 7/22 does not include this requirement.
Rating
Met
Findings
-

Action 1.07
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols

b. Monitor and take action to improve adherence to policies, procedures and protocols

c. Review compliance with legislation, regulation and jurisdictional requirements

Evidence Reviewed

Initial Assessment: Policies and procedures are in place to support ongoing review and maintenance of the information available to staff.

The reviews are in response to updated clinical care standards, changes in regulation or the scope of service of the facility

Legislation and regulatory instruments are included in the policy suite.

Staff describe the overall responsibility for policy review sits with Corporate and Quality Manager.

Staff access the policies and procedures via the Intranet" HINT"

The effectiveness of the Quality Plan resulting from non-compliant audits is unclear.

Example - Quality Plans progress for the surgical floor Medication Fridge Temperature and the Resus Trolley has been ineffective with compliance remaining below the benchmark.

Ensuring that all documents utilised by the workforce are appropriately controlled will ensure that the correct version of a document is available to the workforce. Noted that the Post-natal Care Plan is not document controlled including no Medical Record Number identification.

Final Assessment: Evidence sighted at the final assessment that the Health Information Team have reviewed each clinical area ensuring the correct HMR documentation is available and has refined the process for archiving old, removing out of date documentation and replacing current HMR documentation.

There is a standing agenda item on the Quality and Clinical Governance Committee for on-going review and implementation.

Spot audits are undertaken – sighted spot audit undertaken by the Health Information Manager (HIM) and the Quality Manager 5/24

Discussions with the DON confirmed that this is a discussion item that is undertaken at the DON/NUM bed meeting also.

Huddle Meeting DON/NUM 06/06/24

NUM/DON Meeting Allied Health 05/02/24

Although there has been considerable progress in ensuring that all documents utilised by the workforce are appropriately controlled this will remain a met with recommendations as is yet to be fully implemented.

Management review of the Quality Plans with update of all previous Quality activities in eQuaMS with evidence sighted that Quality Activities demonstrate a 98% completion rate.

Quality Activities is a standing agenda item on relevant committees.

Rating

Met with Recommendations

Findings

Evidence sighted at the final assessment that the Health Information Team have reviewed each clinical area ensuring the correct HMR documentation is available and refined the process for archiving old, removing out of date documentation and replacing current HMR documentation.

There is a standing agenda item on the Quality and Clinical Governance Committee for on-going review and implementation.

Spot audits are undertaken – sighted spot audit undertaken by the Health Information Manager (HIM) and the Quality Manager 5/24

Discussions with the DON confirmed that this is a discussion item that is undertaken at the DON/NUM bed meeting also.

Huddle Meeting DON/NUM 06/06/24

NUM/DON Meeting Allied Health 05/02/24

Although there has been considerable progress in ensuring that all documents utilised by the workforce are appropriately controlled this will remain a met with recommendations as is yet to be fully implemented.

Action 1.08

The health service organisation uses organisation-wide quality improvement systems that:

a. Identify safety and quality measures, and monitor and report performance and outcomes

b. Identify areas for improvement in safety and quality

c. Implement and monitor safety and quality improvement strategies

d. Involve consumers and the workforce in the review of safety and quality performance and systems

Evidence Reviewed

The organisation maintains a quality improvement program by identifying areas for improvement. Inputs to the process include but are not limited to the incident management and reporting system, internal audit program, patient, staff and doctor feedback and clinical indicator reporting. Outputs include reviews of the risk register, eQuaMS Register and key performance indicator reporting. Safety and Quality data is reported through the Committee structure.

The process to involve consumers in the review of safety and quality performance and systems is not fully implemented.

Final Assessment: Evidence was sighted at the final assessment that management have revised the Consumer Engagement Committee (CEC) Meeting TOR 2024 03/24. Two more Consumers have been recruited since the initial assessment.

Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present the following reported:

• Patient Experience

• Safety Share which includes patient rounding, handover, care boards

• Year in review, complaints and complaints, always events, Quality report (Oct-Dec 2023), Consumer Engagement Plan, Business overview, Successes, redevelopment, key personnel changes.

• Annual Planner, portfolio updates, audit schedules, HPH meeting schedule, Consumer Consultant Toolkit review, patient care boards, patient rounding and clinical handover, patient brochures feedback, mandatory training, Reconciliation Action Plan – Aboriginal and Torres Strait Islander Engagement Plan.

Rating

Met

Findings

-

Action 1.09

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

a. The governing body

b. The workforce

c. Consumers and the local community

d. Other relevant health service organisations

Evidence Reviewed

Initial Assessment: Although there is an extensive committee structure in place at Hobart Private Hospital with reporting evident, the process to ensure that timely reports are provided to the relevant committees is not fully implemented.

Final Assessment: Evidence sighted at the final assessment that HPH has reviewed and implemented a Committee Structure which identifies the structure of reporting lines and highest level of governance Committee.

All Committee have documented Terms of Reference (TOR) which outlines their scope and purpose, function, membership, quorum, reporting lines, frequency and review and identifies. All Committee agendas have been reviewed with agenda items for each Committee based on the confirmed TOR. The HPH meeting schedule has been revised based on committee structure and TOR to clearly identify meeting frequency and membership.

Rating

Met

Findings

-

Action 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Evidence Reviewed
Initial Assessment: RiskMan is utilised to document and manage the Risk Register with each risk allocated to an "Accountable Executive" Member with a "next review date" documented. The system generates automated reminders to the allocated "Accountable Executive Member " . The register is proactive and is based on clinical risks. Examples of risks include: Risk ID # 9286 Ineffective relationship with key doctors Risk ID # 9279 Information Security (IT) Risk ID # 9295 Inadequate skills/experience/training of managers Risk ID # 13569 Hospital Security Risk ID # 9342 State Government Licensing Reporting on risks to consumers is not fully implemented. Sighted in the WHS Committee Meeting Minutes 13/12/2023 were discussions around emergency planning with HPH Disaster and Emergency Plan 2024 in place. Final Assessment: Evidence was sighted at the final assessment that management have revised the Consumer Engagement Committee (CEC) Meeting TOR 2024 03/24. Two more Consumers have been recruited since the initial assessment. Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present the following reported: • Patient Experience • Safety Share which includes patient rounding, handover, care boards • Year in review, complaints and complaints, always events, Quality report (Oct-Dec 2023), Consumer Engagement Plan, Business overview, Successes, redevelopment, key personnel changes. • Annual Planner, portfolio updates, audit schedules, HPH meeting schedule, Consumer Consultant Toolkit review, patient care boards, patient rounding and clinical handover, patient brochures feedback, mandatory training, Reconciliation Action Plan – Aboriginal and Torres Strait Islander Engagement Plan.

Rating
Met
Findings
-

Action 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Evidence Reviewed
Initial Assessment: The facility has an organisation-wide incident management and investigation system utilising RiskMan Trending reports on clinical risk reported to the MAC and Quality and Risk committees were sighted. Completion of serious incident review and corrective action plan as required and reported to the relevant committees. Critical System Review (RiskMan ID 346438) was sampled with appropriate management undertaken. Quality Improvement is achieved through regular review and action Feedback to staff through Committee structure and Quality and Safety Boards. The process to ensure that consumers are involved in the review of incidents and the provision of feedback on the analysis of incidents to the consumers is not fully implemented. Final Assessment: Evidence was sighted at the final assessment that management have revised the Consumer Engagement Committee (CEC) Meeting TOR 2024 03/24. Two more Consumers have been recruited since the initial assessment. Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present the following reported:

• Patient Experience

• Safety Share which includes patient rounding, handover, care boards

• Year in review, complaints and complaints, always events, Quality report (Oct-Dec 2023), Consumer Engagement Plan, Business overview, Successes, redevelopment, key personnel changes.

• Annual Planner, portfolio updates, audit schedules, HPH meeting schedule, Consumer Consultant Toolkit review, patient care boards, patient rounding and clinical handover, patient brochures feedback, mandatory training, Reconciliation Action Plan – Aboriginal and Torres Strait Islander Engagement Plan.

Rating

Met

Findings

-

Action 1.12

The health service organisation:

a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework

b. Monitors and acts to improve the effectiveness of open disclosure processes

Evidence Reviewed

Initial Assessment: There is an documented policy in place which guides and informs Staff and Management in open disclosure, 2.30 Open Disclosure 10/23, this policy adheres to the principles and processes outlined in the Australian Open Disclosure Framework. Discussion with the Management verified that open disclosure processes are well understood.

Staff training on Open Disclosure is undertaken with current compliance at 97%.

Although there is an open disclosure policy - 2.30 Open Disclosure 10/23 in place – documentation of the open disclosure process has not occurred in the following medical records reviewed MRN # 134535, MRN # 912082 and MRN 141353, despite been flagged through RiskMan as occurred.

Final Assessment: During the final assessment a review of the following medical records with evidence that open disclosure was undertaken, however the level of documentation is not is not consistent with the policy 2.30 Open Disclosure 10/23.

URN # 376000 incident ID 2124596

URN # 340463 incident ID 2131470

A met with recommendation will remain and will be reviewed further at the mandatory reassessment.

Rating
Met with Recommendations
Findings
During the final assessment a review of the following medical records with evidence that open disclosure was undertaken, however the level of documentation is not is not consistent with the policy 2.30 Open Disclosure 10/23 . URN # 376000 incident ID 2124596 URN # 340463 incident ID 2131470 A met with recommendation will remain and will be reviewed further at the mandatory reassessment.

Action 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
Evidence Reviewed
The organisation has a variety of ways to receive feedback from patients. Patient surveys results sighted with results predominately high. December results sighted 94% NET promoter score is 100%. Staff were engaged throughout the assessment and reported satisfaction with the workplace, a recent staff engagement survey completed in 2023 results were below expected with management continually improving the workplace. Feedback from Doctors is obtained through the Medical Advisory Committee. The CEO and DON is accessible as required to both staff and doctors with a positive working relationship observed throughout the assessment.
Rating
Met
Findings
-

Action 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system
Evidence Reviewed
Initial Assessment: There is a documented complaints policy in place 1.08 Complaints Management 07/22 to guide and inform staff. Complaints maybe received via several means with RiskMan utilised to manage all complaints. Management of complaint Risk # ID 19712 Complaint received from Consumer via the Equal Opportunity Tasmania Resulting in plans for installation, style and placement of 48 tactile ground surfaces indicators from the front driveway to the front door of HPH. Installation of a way finding flooring - Consumer to be involved. Complaints are discussed through the committee framework. The process to ensure that consumers are involved in the review of complaints and the provision of feedback on the analysis of complaints to the consumers is not fully implemented. Final Assessment: Evidence sighted at the final assessment that management have revised the Consumer Engagement Committee (CEC) Meeting TOR 2024 03/24. Two more Consumers have been recruited since the initial assessment. Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present the following reported: • Patient Experience • Safety Share which includes patient rounding, handover, care boards • Year in review, complaints and complaints, always events, Quality report (Oct-Dec 2023), Consumer Engagement Plan, Business overview, Successes, redevelopment, key personnel changes. • Annual Planner, portfolio updates, audit schedules, HPH meeting schedule, Consumer Consultant Toolkit review, patient care boards, patient rounding and clinical handover, patient brochures feedback, mandatory training, Reconciliation Action Plan – Aboriginal and Torres Strait Islander Engagement Plan.

Rating
Met
Findings
-

Action 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher- risk groups into the planning and delivery of care
Evidence Reviewed
The facility has utilised the Australian Bureau of Statistics South East Coast 2021 data to dissect their demographic population with the diversity of the population mainly English speaking. Interpreters are used when necessary and at times the use of family members for interpreting was raised by staff during interviews with assessors. There is a policy to guide and inform staff 2.36 Interpreter Services 6/22. Patients are identified on admission if they are ATSI which is included in Admission documentation. Although the facility has generated a report from their Patient Information Software which includes gender, age, aboriginality, country of birth and language. An opportunity for improvement was raised to ensure that this information is presented through to the Governing Body.
Rating
Met
Findings
-

Action 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations

d. Support systematic audit of clinical information

e. Integrate multiple information systems, where they are used

Evidence Reviewed

Medical Records policies include information on retention and disposal in accordance with state based guidelines and regulation, 2.21 Retention and Disposal of Health Information 5/22. There is also a documented policy on release of Health Information 07/22 which was well understood by the Health Information Manager.

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

Regular medical record documentation audits are conducted with non conforming results resulting in an action plan.

Ensuring that pencil is not utilised in the medical records and that all staff document their designation will strengthened documentation processes.

Rating

Met

Findings

-

Action 1.17

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

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

b. Use national patient and provider identifiers

c. Use standard national terminologies

Evidence Reviewed

My Health Record is currently in use by the facility. There is a policy to guide and inform staff, 2.66 My Health Record System 5/21. My Health Records information brochures are available for patients in the clinical areas.

Rating

Met

Findings
-

Action 1.18
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system
Evidence Reviewed
My Health Record is currently in use by the facility. Monitoring is completed utilising a NSD Summary report which is distributed to Managers Monthly.
Rating
Met
Findings
-

Action 1.19
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
Evidence Reviewed
Orientation is provided to all staff utilising an orientation checklist with all areas having a area specific Orientation Manual. Agency staff usage remains high with the facility a utilising a checklist for orientation , completed orientation checklist are maintained by the DON with a folder for agency orientation situated in each clinical area. The VMO are all provided with the Healthscope Limited Bylaws 7/18.
Rating
Met

Findings
-

Action 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
Evidence Reviewed
Staff at Hobart Private Hospital utilise an eLearning platform to complete a component of their training with current completion rate at 74.61%. The staff development unit responsibilities include conducting orientation and ensuring the completion of the mandatory training. A training needs analysis is for 2024 which is incorporated into the 2024 Education Plan. Management have recently provided extra resources into the training program with each clinical area having a educator at least 2 days week. Staff Development Unit - 2024 Education Plan Staff Development Unit 2-23-2024 Training Records Although the training requirements for VMOs have been identified and management are in the process of capturing this information, along with a Mandatory Training program in place for employed staff, on review of the training completion rates there were identified gaps (Medsafe 30% ALS 46% Resus4kids 35%) which will be assessed at the final assessment. Noted that a training day is scheduled for 28th March which will assist with compliance. Final Assessment: Evidence sighted that management continue to implement the training program with compliance rates as of 20/05/24 BLS 72% ALS 44% Resus4Kids 46% and Manual Handling 76% MedSafe 56%. Management continue to capture VMO training continues, the process is yet to be fully implemented.
Rating
Met with Recommendations
Findings
Evidence sighted that management continue to implement the training program with compliance rates as of 20/05/24 BLS 72% ALS 44% Resus4Kids 46% and Manual Handling 76% MedSafe 56%. Management continue to capture VMO training continues, the process is yet to be fully implemented.

Action 1.21
The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Evidence Reviewed
Staff are required to complete education in order to demonstrate cultural competence. The previous required training module "Share our Pride" showed 88% completion rate with a new education introduced approx. 3 months "Cultural Diversity and Sensitivity in Healthcare" ago with a completion rate of 59 % to date.
Rating
Met
Findings
-

Action 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Evidence Reviewed
Initial Assessment: There is a documented policy in place to inform and guide both management and staff 4.14 Performance Review and Development 4/22. The health service organisation provides feedback The NUM is responsible for the performance review of their staff with reporting to the Director of Nursing. Processes to ensure that the members of the workforce regularly take part in a review of their performance review is not fully implemented. Performance and Development Form 11/21 prompts a review of the position description at this time. Processes to ensure that the members of the workforce regularly take part in a performance review is not fully implemented. Performance review completion rate is 50.5%.

Final Assessment: Evidence sighted at the final assessment that management now utilise the Dimensions platform to capture performance appraisal compliance with Department Managers plan and schedule appraisals dates. Reporting compliance occurs at the NUM/DON meeting and the Quality and Clinical Governance Committee.

Current appraisal completion rate 75%

Huddle Meeting DON/NUM 06/06/24

NUM/DON Meeting Allied Health 05/02/24

A met with recommendation will remain and will be reviewed further at the mandatory reassessment.

Rating

Met with Recommendations

Findings

Evidence sighted at the final assessment that management now utilise the Dimensions platform to capture performance appraisal compliance with Department Managers plan and schedule appraisals dates. Reporting compliance occurs at the NUM/DON meeting and the Quality and Clinical Governance Committee.

Current appraisal completion rate 75%

Huddle Meeting DON/NUM 06/06/24

NUM/DON Meeting Allied Health 05/02/24

A met with recommendation will remain and will be reviewed further at the mandatory reassessment.

Action 1.23

The health service organisation has processes to:

a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan

b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice

c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered

Evidence Reviewed

Scope of practice is defined as a component of credentialing with approval letters issued to each successful credentialed Practitioner with the Scope of Practice outlined. Monitoring is conducted via the credentialing process through cGov.

VMO are assigned scope of practice based on their college training and admitting rights to ensure their scope is clearly defined prior to service precision.

Interim rights may be granted depending of scope of proactive and risk.

The adoption of new technologies is described in the document Healthscope Limited Bylaws 7/18.

Rating

Met

Findings

-

Action 1.24

The health service organisation:

a. Conducts processes to ensure that clinicians are credentialed, where relevant

b. Monitors and improves the effectiveness of the credentialing process

Evidence Reviewed

There is a formal credentialing process for clinicians designed to reflect their scope of practice with the use of Cgov with a corporate policy in place which outlines the process 1.20 Accredited Health Practitioners' Credentials 6/22.

AHPRA registration is monitored annually for VMO, nursing and allied health staff.

Credentialing of medical officers is described in the Healthscope Limited Bylaws 7/18 which is provided to VMO on successful credentialing.

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

Credentialing is completed every 5 years with initial credential approval only for 12 months.

The effectiveness of the credentialing process is monitored via the National Audit Schedule.

Rating

Met

Findings

-

Action 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Evidence Reviewed
Job descriptions contain statements about requirements for incorporating safety and quality principles for staff when fulfilling their role. The facility uses agency nursing staff to ensure appropriate staffing numbers consistent with clinical activity. Agency staff receive an orientation from a staff member with a orientation manual utilised sighted orientation checklists for both staff and agency sighted.
Rating
Met
Findings
-

Action 1.26
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Evidence Reviewed
Supervision is provided in the facility by appropriately qualified management and staff. The hospital has an after hours co-ordinator to assist with any issues that may arise out of hours. The Emergency department Doctor is on site at all times in the facility. Doctors contact details are available to staff. Discussion with staff during the assessment verified that appropriate supervision is provided to clinicians.
Rating
Met
Findings
-

Action 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Evidence Reviewed
Sufficient tools and information is available to clinicians at the point of care via HINT. Tools include but are not limited to Clinical Care Standards Injectable Handbooks Therapeutic Guidelines eMIMS are available on all computer desktops
Rating
Met
Findings
-

Action 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
Evidence Reviewed
Variation in practice is monitored through the organisation submitting their outcomes to clinical indicator data sets which include ACHS Clinical Indicators, Healthscope HAC reports, RiskMan incident reports and complaints. Data from these bodies /software enables feedback to clinicians and benchmarking

activity. If individual variation is identified it would be discussed at Medical Advisory Committee. Discussion with the General Manager and the MAC Chairman whom demonstrated a sound knowledge of this process and has not identify any unwarranted clinical variation is recent times.

Minutes of the MAC 07/12/2023 were sighted with all ACHS 2H 2022 outliers (5 in total) discussed and HPH QKPI report with outliers discussed.

Craft Groups include Maternity and Paediatric Services Committee minutes sighted 23/02/2023 and 4/05/2023 and the Anaesthetic and Surgical Committee Meeting minutes sighted 10/05/2023 – 5/07/2023 – 1/11/2023.

Rating

Met

Findings

-

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment

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

Evidence Reviewed

The preventative maintenance schedule managed by the Kwicklook software program with oversight of the program with the WH&S officer. There is a maintenance manager on site Monday to Friday with the Hospital Co-ordinators arranging maintenance afterhours if required .All biomedical equipment and Body protection areas contained compliance plates sighted during the assessment were noted to be in date with the exception of one on level 4 surgical which was rectified on the day on the assessment. Sampling of records include TMV, Backflow reports, theatre air conditioning reports inclusive of HEPA reports, generator servicing and servicing of the blood fridge were sampled. Processes are in place to ensure that infrastructure is fit for purpose with current renovations to bathrooms currently being undertaken.

The Essential Safety Services Measures Assessment 7/03/2024 where two non conformances were identified, the facility have created an entry in RiskMan ID# 2123503.

There is also a reactive maintenance process for staff to quickly respond to breakages and other maintenance issues in order to minimise patient risk with a maintenance manager on site during business hours.

Rating

Met

Findings
-

Action 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Evidence Reviewed
Instances of unpredictable behaviour are reportedly rare, displayed in the clinical areas is a Code of Conduct which outlines expected behaviour from Patients and Visitors. There are a number of WH&S policies in place 06.15 a) Occupational Violence and Aggression - Incident Management 8/23, 6.15 Occupational Violence and Aggression OVA Management Principles and Prevention 08/23. Emergency Plans and internal phone directories are available for staff. Emergency flip charts where sighted in appropriate locations with staff confirming when they would be used. There is restricted entry into the hospital after hours. Staff undertake training in Managing Conflict & Challenging Behaviour with a completion rate of 71%. The patient accommodation, with a number of single rooms creates good opportunities to provide safer places to provide a calm and quieter environment when clinically required. Common rooms are available for patients in areas of potential risk. These include, reception, emergency and recovery areas. Each area have access to quiet spaces. Zero tolerance posters are displayed.
Rating
Met
Findings
-

Action 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose

Evidence Reviewed
Signage is clear and sensible. Reception is attended to by staff who can direct patients and visitors. There is a directory to assist with directions located at reception and in each lift. All staff are in uniform and were willing to assist with directions.
Rating
Met
Findings
-

Action 1.32
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
Evidence Reviewed
Discussions with management and staff confirmed that Hobart Private Hospital has flexible visiting arrangements to meet patients needs with overnight stays permitted if clinically indicated. Examples provided include social support or during end of life care and parents of paediatric patients. There is a documented policy in place 2.62 Visiting Hours Flexible Arrangements 10/2019 to guide and inform Management and Staff of processes. Information is also available on the website.
Rating
Met
Findings
-

Action 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Evidence Reviewed
Corporate documents include The Healthscope Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan Jan 2024- Dec 2025, this documents sets out the framework to develop relationships with Aboriginal and Torres Strait Islander Communities.

There is an Acknowledgement of Country policy in place 1.03 dated 02/22 with acknowledgement of Country conducted at the commencement of each committee meeting.

Artwork is displayed in public spaces together with a short bio on the painter. Acknowledgement of country signage is displayed in the public areas.

The Quality Manager has availed of opportunities to engage with local communities which include visits to Risdon Cove with invitations extended to this community to visit the hospital, a visit to the Royal Hobart Hospital to build relationships with the ALO, engagement with a local ATSI Teacher with whom engagement activities were shared, attendance at a Smoking Ceremony at the Community Centre.

In the maternity unit books on Maternity by an ATSI Author were given to parents as a gift.

Management have identified workforce members who identify as ATSI who could be consulted if required.

Information brochures are available which included Aboriginal Health Services Information Sheet.

Training in "Cultural Diversity and Sensitivity in Healthcare" is undertaken by the workforce.

Celebration of NAIDOC week in July 2023 was undertaken.

Rating

Met

Findings

-

Action 2.01

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for partnering with consumers

b. Managing risks associated with partnering with consumers

c. Identifying training requirements for partnering with consumers

Evidence Reviewed

Initial Assessment: Corporate policies describing the process of Partnering with Consumers which include:

1.05 Partnering with Consumers 11/2021 and Consumer Engagement Plan 2021-2024.

Hobart Private Hospital has recently recruited two Volunteer Consumer Consultants to assist with the implementation of these policies.

Consumer representatives are required to undergo Training for the role with one Consumer completing the required "Foundations "Module x 4 and the second Consumer completing 2 modules to date. There are Terms of Reference for the Consumer Engagement Committee which are under review.

The Volunteer Consumer Consultant Position Description articulates their Roles and Tasks.

RiskMan is utilised to manage risks associated with partnering with consumers which include

Risk ID # 18834 Partnering with Consumers

Risk ID # 9341 Inadequate Complaints Management

Training requirements for partnering with consumers is scheduled on the training on the eLearning platform "Relationship Centred Caring " with completion rate at 74%.

Implementing policies and procedures for partnering with consumers at Hobart Private Hospital is not fully undertaken.

Final Assessment: Evidence sighted at the final assessment that management have revised the Consumer Engagement Committee (CEC) Meeting TOR 2024 03/24. There is a HPH Consumer Engagement Plan 2024-2025 plan in place.

Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present.

Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024 with Patient Consumer Experience a standing agenda item with reporting from the Consumer Engagement Committee evident.

Rating

Met

Findings

-

Action 2.02

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

a. Monitoring processes for partnering with consumers

b. Implementing strategies to improve processes for partnering with consumers

c. Reporting on partnering with consumers

Evidence Reviewed

Initial Assessment: Monitoring processes for partnering with consumers is scheduled on the National Audit Schedule with current strategies focused on recruitment of Volunteer Consumer Consultants QA # 9450 and strengthen Consumer Consultant recruitment QA # 4807.

As processes for partnering with consumers is yet to be fully implemented, monitoring and reporting on partnering with consumers is also not fully implemented.

Final Assessment: Evidence sighted at the final assessment that consumers have been involved in the governance of, and to design, measure and evaluate, health care of HPH via the Consumer Engagement Committee (CEC) which is reported up to the Quality and Clinical Governance Committee.

Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present.

Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024

The committee structure and TOR to clearly identify meeting frequency.

MARS# 243 Consumers Program Audit Report sighted.

Rating

Met

Findings

-

Action 2.03

The health service organisation uses a charter of rights that is:

a. Consistent with the Australian Charter of Healthcare Rights

b. Easily accessible for patients, carers, families and consumers

Evidence Reviewed

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

Rating

Met

Findings

-

Action 2.04

The health service organisation ensures that its informed consent processes comply with legislation and best practice

Evidence Reviewed

There is a documented policy which addresses informed consent, 2.17 Consent to Medical/Surgical Treatment 12/22.

All Medical records sighted during the review contained a signed consent. Monitoring processes for Consent for Medical/Surgical/Procedural Audit is scheduled on the National Audit Schedule (Audit # 244). Informed Financial Consent is consistent with the Advisory AS 18/10.

Rating
Met
Findings
-

Action 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Evidence Reviewed
There is a documented policy which addresses informed consent and the capacity of patients to consent to treatment and to involve a substitute decision maker, 2.17 Consent to Medical/Surgical Treatment 12/22.
Rating
Met
Findings
-

Action 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Evidence Reviewed
Initial Assessment: Policies 2.69 Comprehensive Care Plan and 2.17 Consent to Medical/Surgical Treatment 12/22 discusses how patients plan, communicate, set goals, and make decisions about their current and future care. Patient Care Boards are available in patient rooms. Clinical Handover was witnessed in several clinical areas (surgical, cardiology, maternity and medical) to confirm that clinicians partner with their patients to plan, communicate and make decisions about care.

Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented.

Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care.

Final Assessment: Final Assessment: Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.

Rating

Met with Recommendations

Findings

Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.

Action 2.07

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

Evidence Reviewed

The Patient Survey is based on the AHPEQS questions which includes a question regarding decision making - results to the ongoing surveys have been positive.

Information is available to patients via brochures and the website to assist in decision making. Clinical handover incorporates the patient.

Assessors observed full engagement of patients with appropriate information being disseminated to patients during witnesses patient episodes.

Patients interviewed during the assessment confirmed the clinical handover policies include the patient and their family.

Training requirements for partnering with consumers is scheduled on the training on the eLearning platform "Relationship Centred Caring " with completion rate at 74%.

Rating
Met
Findings
-

Action 2.08
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
Evidence Reviewed
The facility has utilised the Australian Bureau of Statistics South East Coast 2021 data to dissect their demographic population with the diversity of the population mainly English speaking. Although the facility has generated a report from their Patient Information Software which includes gender, age, aboriginality, country of birth and language. An opportunity for improvement was raised to ensure that this information is presented through to the Governing Body. The Australian Charter of Healthcare rights (ACHCR) is available in a number of different languages and is displayed in patient waiting areas.
Rating
Met
Findings
-

Action 2.09
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
Evidence Reviewed
Initial Assessment: Corporate policies on consumer participation include how information is reviewed by consumers, families and their carers. Local consumers have been involved in the past in the review of patient information, however this has not occurred for some time. Processes will recommence once the Consumer Engagement Committee has occurred. Final Assessment: Evidence sighted at the final assessment that consumers have been involved in the review of Condolence Cards – via email dated 11/04/2024. Sighted the Patient Brochure Index last review 5/24 with evidence that a number of documents are awaiting Consumer feedback.

This process will be managed through the Consumer Engagement Committee moving forward.

Rating

Met

Findings

-

Action 2.10

The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

a. Information is provided in a way that meets the needs of patients, carers, families and consumers

b. Information provided is easy to understand and use

c. The clinical needs of patients are addressed while they are in the health service organisation

d. Information needs for ongoing care are provided on discharge

Evidence Reviewed

Clinical areas were accessed by the assessment team to ensure the organisation supports their staff to communicate with consumers regarding their health care. If necessary, staff will arrange for an interpreter to ensure that communication with a patient is meaningful. The patient information booklet has been prepared to provide patients with information about the hospital's services. Staff describe the following policies and processes. Clinical handover was witnessed during transitions of care which adhered to the policy 8.18 Clinical Handover - Departmental and Intra-Unit 10/20. The use of Patient Care Boards are in place in the clinical area.

Rating

Met

Findings

-

Action 2.11
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
Evidence Reviewed
Initial Assessment: Processes to involve consumers in partnerships in the governance of, and to design, measure and evaluate, health care is not yet fully implemented. Final Assessment: Evidence sighted at the final assessment that consumers have been involved in the governance of, and to design, measure and evaluate, health care of HPH via the Consumer Engagement Committee (CEC) which is reported up to the Quality and Clinical Governance Committee. Meeting minutes sighted 22/03/2024, 24/05/2024 with four Consumers present. Quality and Clinical Governance Minutes of Meeting 16/04/2024 and 28/05/2024
Rating
Met
Findings
-

Action 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Evidence Reviewed
Hobart Private Hospital has recently recruited two Volunteer Consumer Consultants to assist with the implementation. Consumer representatives are required to undergo Training for the role with one Consumer completing the required "Foundations" Module x 4 and the second Consumer completing two modules to date. The Volunteer Consumer Consultant Position Description articulates their Roles and Tasks. There was an opportunity to discuss the orientation process with one consumer who is looking forward to fulfilling this role.
Rating
Met

Findings
-

Action 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Evidence Reviewed
Corporate documents include The Healthscope Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan Jan 2024- Dec 2025, this documents sets out the framework to develop relationships with Aboriginal and Torres Strait Islander Communities. There is an Acknowledgement of Country policy in place 1.03 dated 02/22 with acknowledgement of Country conducted at the commencement of each committee meeting. Artwork is displayed in public spaces together with a short bio on the painter. Acknowledgement of country signage is displayed in the public areas. The Quality Manager has availed of opportunities to engage with local communities which include visits to Risdon Cove with invitations extended to this community to visit the hospital, a visit to the Royal Hobart Hospital to build relationships with the ALO, engagement with a local ATSI Teacher with whom engagement activities were shared, attendance at a Smoking Ceremony at the Community Centre. In the maternity unit books on Maternity by an ATSI Author were given to parents as a gift. Management have identified workforce members who identify as ATSI who could be consulted if required. Information brochures are available which included Aboriginal Health Services Information Sheet. Training in "Cultural Diversity and Sensitivity in Healthcare" is undertaken by the workforce. Celebration of NAIDOC week in July 2023 was undertaken.
Rating
Met
Findings
-

Action 2.14
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Evidence Reviewed
Hobart Private Hospital utilise patient reflections to incorporate their views and experiences into training and education for the workforce, which are discussed at the beginning of committee meetings. Quality Boards have been installed in each department to display feedback and performance data to both patients and staff.
Rating
Met
Findings
-

Action 3.01
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d Identifying and managing antimicrobial stewardship risks
Evidence Reviewed
Assessors reviewed infection control procedures and processes which were consistent with the safety and quality systems from the Clinical Governance Standard. These principles underpin the implementation of policies and procedures, risk management and determining training requirements for preventing and controlling healthcare associated infections and antimicrobial stewardship. Staff were able to describe how they operationalise infection control related policies and procedures, how associated risks are managed and describe the training provided regarding antimicrobial stewardship and preventing and controlling healthcare associated infections. Infection Prevention and Control - HICMR Policies, noted that during the assessment the hospital was also undertaking their two (2) yearly HICMR audit.
Rating
Met
Findings
-

Action 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Evidence Reviewed
HPH reports any infection prevention and control associated risks through the regular committee structure (See action 1.01). HPH has specific responsibilities for improving infection prevention surveillance and workforce training which was evidenced to the assessors.
Rating
Met
Findings
-

Action 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources

Evidence Reviewed
Initial Assessment: HPH has a comprehensive audit schedule for infection prevention and control systems. Audit results are provided to staff and data is provided through the committee structure. Infection control and prevention including antimicrobial stewardship are discussed at staff meetings and strategies are documented to improve performance where gaps are identified. However, the reporting processes for AMS outcomes to patients/consumers is not fully implemented. Final Assessment: Evidence sighted at the final assessment that reporting on AMS outcomes to the Consumers has occurred – Consumer Engagement Committee Minutes sighted 24/05/2024. There was a Consumer present at Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) combined meeting committee minutes dated 21/05/2024 where AMS outcomes were discussed. AMS data is now displayed on the Safety and Quality Boards.
Rating
Met
Findings
-

Action 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Staff interviewed by assessors were able to describe the actions taken to involve and inform them about infection prevention and control and AMS measures. At HPH information is available to patients, carers and families in a format that is easily understood.
Rating
Met
Findings
-

Action 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Evidence Reviewed
Initial Assessment: HPH monitors and collects data on healthcare related infections and antimicrobial used as well as broader infection control surveillance data. Reports on healthcare related infections and antimicrobial use are provided to clinicians and reported through the committee structure. However, reporting processes for AMS outcomes to patients/consumers is not fully implemented. Final Assessment: Evidence sighted at the final assessment that reporting on AMS outcomes to the Consumers has occurred – Consumer Engagement Committee Minutes sighted 24/05/2024. There was a Consumer present at Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) combined meeting committee minutes dated 21/05/2024 where AMS outcomes were discussed. AMS data is now displayed on the Safety and Quality Boards.
Rating
Met
Findings
-

Action 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Evidence Reviewed
The review of infection control documents at HPH specifically transmission based precautions indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare standard. Healthscope Standard and Transmission-Based Precautions - 15.03.
Rating
Met
Findings
-

Action 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission- based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Evidence Reviewed
HPH has policies and processes for the management of organisms-specific risks, including prevalence in the community is in place that are consistent with jurisdictional and Public Health advice (COVID). Fit testing/checking training is undertaken, with adequate PPE available for all staff.

Documentation and communication of infectious status is included with all pre-op documentation and communication is included in transfer of care and discharge processes. HPH staff undertake mandatory training for the appropriate use of standard and transmission-based precautions.

Rating

Met

Findings

-

Action 3.08

Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider:

a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care

b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance

c. Accommodation needs and patient placement to prevent and manage infection risks

d. The risks to the wellbeing of patients in isolation

e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes

f. Precautions required when a patient is moved within the facility or between external services

g. The need for additional environmental cleaning or disinfection processes and resources

h. The type of procedure being performed

i. Equipment required for routine care

Evidence Reviewed

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

Rating

Met

Findings

-

Action 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Evidence Reviewed
Communication of a patient's infectious status is included at all transfer of care/handover points and compliance is monitored. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry points of clinical areas.
Rating
Met
Findings
-

Action 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Evidence Reviewed
The Hand Hygiene program is consistent with the current National Hand Hygiene Initiative (NHHI) and jurisdictional requirements. The organisation has access to Hand Hygiene auditors that have undertaken the NHHI training. Regular compliance and observational audits are undertaken and provided to staff and displayed on staff boards. Current compliance rates are 92.5% quarter 3 2023 and 88.6% quarter 1 2024. The organisation is compliant with the requirements of Advisory AS20/01.
Rating
Met

Findings
-

Action 3.11
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Evidence Reviewed
Processes for aseptic technique are in place. Staff are appropriately trained, and competency / compliance is monitored. Assessor was able to review audit results and identified training compliance of 85%.
Rating
Met
Findings
-

Action 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17
Evidence Reviewed
Training and assessment for the management of invasive devices are available to staff and align with the current best practice.
Rating
Met
Findings
-

Action 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
Evidence Reviewed
Cleaning procedures and schedules are in place with regular auditing and reports made available through the committee structure. A sample of cleaning schedules for HPH were reviewed by the assessors and staff interviewed regarding cleaning processes had a good knowledge and understanding of the cleaning requirements.
Rating
Met
Findings
-

Action 3.14
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning

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

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
Initial Assessment: HPH has comprehensive workforce immunisation program in place that complies with the jurisdictional policy and national guidelines. Immunisation status is captured during the recruitment process, however it is not inclusive of the VMOs. Final Assessment: Evidence sighted at the final assessment that progress has been made in the capturing of the immunisations information for the VMO, but not yet fully implemented. A VMO training and immunisation spreadsheet has been implement to assist with monitoring.
Rating
Met with Recommendations
Findings
Evidence sighted at the final assessment that progress has been made in the capturing of the immunisations information for the VMO, but not yet fully implemented. A VMO training and immunisation spreadsheet has been implement to assist with monitoring.

Action 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Evidence Reviewed
HPH has an annual influenza vaccination program and 100% of the workforce are fully vaccinated for COVID-19. There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. The program for workforce screening and workplace exclusion is aligned with Tasmanian Health directions. A tiered approach to outbreak and pandemic planning and management is in place.
Rating
Met
Findings
-

Action 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient

• the procedure

• the reusable equipment, instruments and devices that were used for the procedure

c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections

Evidence Reviewed

Available infection control documents indicate that processes are in place for quality management of reprocessing reusable equipment, instruments and devices including: Infection Prevention and Control - HICMR Policies. The assessors observed processes and flows that have been implemented ensured an efficient process with all RMD's meeting AS4187 standard and ACSQHC Advisory AS18/07. Interviews with management and staff involved in reprocessing RMDs confirmed that relevant standards are followed.

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

Rating

Met

Findings

-

Action 3.18

The health service organisation has an antimicrobial stewardship program that:

a. Includes an antimicrobial stewardship policy

b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing

c. Has an antimicrobial formulary that is informed by current evidence- based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes

d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard

e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement

Evidence Reviewed

HPH has established an antimicrobial stewardship program that is guided by evidenced based policy. The AMS Program is implemented by the AMS committee, with local formulary approval, education, monitoring and corrective action as required.
Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use.

Rating

Met

Findings
-

Action 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Evidence Reviewed
HPH documentation showed that the antimicrobial stewardship program is audited to review the antimicrobial prescribing and use, including surveillance data on antimicrobial resistance. The program is evaluated and performance is monitored with reports provided to clinicians via the Clinical Care Standard Anti-Microbial Stewardship (AMS) Committee. Clinicians interviewed were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing. The requirements of the Advisory AS18/08 have been met.
Rating
Met
Findings
-

Action 4.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management

b. Managing risks associated with medication management

c. Identifying training requirements for medication management

Evidence Reviewed

HPH has in place a hospital-wide systems for safety in the supply, storing, prescribing and administration of medication which is outlined in the following policies 18.89 Medication Safety Governance including APINCHS 07/2023, 18.01 Medications Orders and Administration 5/2021, 18.75 Medication Management Plan 11/2019, 2.45 Alerts- Documentation and Management 10/20, 18.85 Best Possible Medication History, Obtaining of 4/21,18.49 Discharge Medication 4/2023, 18.02 Enrolled Nurse - Administration of Medication 10/2021, 18.34 Intravenous (IV) Therapy -Medications and Infusions 6/22.

A robust system for the reporting of medication incidents is in place and the hospital continues to strive to operate in a culture that encourages staff to report any medication incident or near miss which are recorded in RiskMan with all incidents reported through the Medication Safety Committee minutes sighted 5/09/2023.

Risks associated with medication management are documented within the risk register and reviewed regularly.

Risk ID # 9273 Patient Controlled Analgesia (PCA) - inadequate management

Risk ID # 9316 Medication Administration – medication error

Risk ID # 9308 Patients Own Medication - unsafe storage

Risk ID # 9317 Post Operative Medication Orders - incorrectly prescribed

Risk ID # 9367 Illegible Medication Order

Patients individual risk is assessed via the Comprehensive Risk Screening - Part B Medication Management Risk

Hobart Private Hospital has identified training requirements for medication management which include Med Safe (Refer to 1.20).

The pharmacist is involved in the education of the staff with at least 4 in-services completed annually.

Rating

Met

Findings

-

Action 4.02

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

a. Monitoring the effectiveness and performance of medication management

b. Implementing strategies to improve medication management outcomes and associated processes

c. Reporting on outcomes for medication management

Evidence Reviewed

Initial Assessment: The medication system operates within a framework of quality improvement and includes the ongoing monitoring of both the effectiveness and

performance improvement of medication management across the whole of the hospital. Strategies to improve the medication management system are

introduced if required and focus on the improvement of medication management outcomes and processes which is completed via eQuaMS Register QA # 11671 NSMC Audits 2023-2024 and QA # 8902 Medication Fridge Audit.

Monitoring and outcomes are reported to the relevant committees - Medication Safety Committee, minutes sighted 5/09/2023. Attendance included CMO, Pharmacist, Clinical NUMS, Quality Manager and DON. Medication Safety Committee Terms of Reference 2023 are in place with objectives which include but not limited to the review of all medication incidents and adverse events, including notifiable adverse drug reactions, ACHS clinical indicators relating to medicines, KPI's related to medication, audit data related to medication and review medication policies and procedures and make recommendations as required.

Verified that no standing orders are in place at Hobart Private Hospital. Nurse Initiated medication were discussed at Medication Safety Committee 5/09/2023.

The facility has implemented the NIMC and its use is well embedded, however, the introduction of the paediatric NIMC has yet to occur.

During the assessment it was identified that a VMO is utilising a stamp to facilitate the prescribing of their medications (UR# 307507).

The Nurse Initiated Medication Policy -Registered Nurse/Midwife-Initiated Medication Administration (Adults only) 10/23 is a corporate policy, there is an opportunity for improvement to ensure that it is presented through the local Medical Advisory Committee.

Final Assessment: Although the use of the Paediatric NIMC was tabled at the National Paediatric Committee for Healthscope, it was determined that it will not implemented at HPH. Processes have been established to ensure safe medication management for paediatric patients, including recording of patient weight on all NIMC and a Paediatric/Neonatal Prescription form protocol that needs to accompany all NIMC. Therefore, there is sufficient evidence for this action to remain as a Met with Recommendations and not escalate, however these processes are not fully implemented.

Evidence was also reviewed by the assessment team at the final assessment that the use of stamps by VMOs is no longer permitted at HPH and the Nurse Initiated Medication Policy has been reviewed at the MAC (27/03/2024).

Rating

Met with Recommendations

Findings

Although the use of the paediatric NIMC was tabled at the National Paediatric Committee for Healthscope, it was determined that it will not implemented at HPH. Processes have been established to ensure safe medication management for paediatric patients, including recording of patient weight on all NIMC and a Paediatric/Neonatal Prescription form protocol that needs to accompany all NIMC. Therefore, there is sufficient evidence for this action to remain as a Met with Recommendations and not escalate, however these processes are not fully implemented.

Action 4.03
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
HPH has a strong focus on the involvement of consumers, carers, and patients in medication management. Every effort is made by staff to ensure that there is a clear understanding of the effects of prescribed medications and their correct use during their stay and prior to patient discharge. Patients and/or carers are encouraged to ask questions and importantly report any side effects or other reactions they may be experiencing. Patients are also be provided with information in either verbal, written form, or both to inform them on any special instructions, directions and/or precautions. This information is made available to the carers and /or families who may be monitoring the administration of a patient's prescribed medication post discharge. Staff can also organise individual sessions with the Pharmacist as required.
Rating
Met
Findings
-

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

Findings
-

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

Action 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Evidence Reviewed
The review of prescribed medications against a patient's initial best possible medication history is ongoing and forms part of the treatment plan for all patients. The VMO and/or the Pharmacist are involved in this process with evidence sighted in the medical records sampled.
Rating
Met
Findings
-

Action 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
Evidence Reviewed
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. The use of an alert sheet which is located in the patient bedside folders ensures that information is close at hand and is utilised at key patient care episodes. Discussion with staff and sampling of patient records verified these processes.
Rating
Met
Findings
-

Action 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Evidence Reviewed
The medication error reporting systems are maintained by a hospital-wide approach to supporting and encouraging medication adverse drug reactions reporting by both documenting in the clinical record and RiskMan. Medication error incident reviewed RiskMan # 2123053 with all medication incidents reviewed by the Medication Safety Committee. This process contributes to and is a focus to manage medication risks and uses the investigation of medication error/s and near misses to improve medication safety.
Rating
Met
Findings
-

Action 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Evidence Reviewed
Policies and guidelines are in place to report adverse drug reactions experienced by patients in their care journey to the Therapeutic Goods Administration (TGA). There is also an entry in the Risk Register Risk ID # 9327 27 Therapeutic Goods Administration (TGA) - failure to notify. Discussions with the Pharmacist confirmed the reporting process to TGA.
Rating
Met
Findings
-

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

Action 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks

Evidence Reviewed
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Information is provided to patient on medication reviews and a pharmacist review can requested by staff or patients.
Rating
Met
Findings
-

Action 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes
Evidence Reviewed
A component of discharge documentation is the provision of a current medicines list which is given to the patient on discharge. This process was verified through the sampling of medical records and through discussions with the Pharmacist (UR# 970201).
Rating
Met
Findings
-

Action 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Evidence Reviewed
Clinicians have access to information and medication management support tools both electronic and hardcopy. Staff have access to a pharmacist Mon- Fri business hours and Sat-Sun 9-1 with an on call pharmacist available at all other times. Management are in the process of purchasing iPad for each medication room to ensure electronic access to the resources is close at hand.

SGLT2 Guidelines displayed for staff together with Nurse Initiated Medications.

Rating

Met

Findings

-

Action 4.14

The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the:

a. Safe and secure storage and distribution of medicines

b. Storage of temperature-sensitive medicines and cold chain management

c. Disposal of unused, unwanted or expired medicines

Evidence Reviewed

Hobart Private Hospital adheres to the jurisdictional requirements for the safe and secure storage, recording and administration of medication as evidenced by assessors in the clinical areas. The storage of temperature sensitive medicines, storage, disposal was all evidenced with records maintained (Refer to 1.07). There was an opportunity to observe a number of patient episodes including schedule 8 medication administration by two Registered Nurses UR# 919522 and UR# 917350 and checking Patient Controlled Analgesia settings against the PCA order UR# 121895 and UR# 375524. Drug registers were reviewed during the assessment in theatre and recovery with appropriate recording noted including discards, staff interviewed during the assessment also verified the processes around the disposal of unused, unwanted or expired medicines.

Rating

Met

Findings

-

Action 4.15

The health service organisation:

a. Identifies high-risk medicines used within the organisation

b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Evidence Reviewed

Interviews with staff and supporting documents and assessor observations that high risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. High risk medication labelling in the Maternity and HME ward consistent with the other clinical areas was rectified on the day of the assessment. Scheduled drugs are recorded in appropriate registers and audited within the audit framework.

18.89 Medication Safety Governance including APINCH 07/23.

Rating

Met

Findings

-

Action 5.01

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for comprehensive care

b. Managing risks associated with comprehensive care

c. Identifying training requirements to deliver comprehensive care

Evidence Reviewed

The requirements of this action are well supported by the management of HPH through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards, support clinicians to deliver comprehensive care. Assessors reviewed the following documentation including but not limited to: Comprehensive Care Plan - 2.69 ; Comprehensive Risk Screening Tool - 2.70; Advanced Care Directives - 2.56; Alerts - Documentation and Management - 2.45; Consent to Medical/Surgical Treatment - 2.17 and Falls Prevention and Management - Patient -8.04.

Rating

Met

Findings

-

Action 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Evidence Reviewed
Comprehensive care is defined and monitored with outcomes and audits reviewed at the Quality, Clinical Review, Medical Advisory and Executive Committee meetings. HPH uses feedback, data and outcomes together with evidenced based practice to support improvements in care.
Rating
Met
Findings
-

Action 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Processes are in place to partner with patients in their care and associated decision-making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. Assessors observed staff and clinician interviews with patients throughout the entire patient journey, that were patient centred and involved shared decision-making.
Rating
Met
Findings
-

Action 5.04
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care
Evidence Reviewed
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. HPH operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processed for referral where needed. The clinician with overall accountability for a patient's care is defined as admitting VMO at HPH.
Rating
Met
Findings
-

Action 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Evidence Reviewed
Roles and responsibilities are clearly defined through contracts and position descriptions. A system is in place for orientation, performance review and ongoing education.
Rating
Met
Findings
-

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

Action 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
Evidence Reviewed
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Staff were able to describe the risk assessment process and evidence was sighted in clinical documentation. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The organisation is compliant with the requirements of Advisory AS18/14.
Rating
Met
Findings
-

Action 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems

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

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

Action 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Evidence Reviewed
A comprehensive assessment is conducted on admission. Risk screening processes are subject to audits and reports are reviewed at the NSQHS Standard 5 & 6 - Comprehensive Care and Communicating for Safety Committee and reported through HPH Committee structure. A limited review of clinical documentation by the assessors verified this process is in place including in the Maternity ward.

Rating
Met
Findings
-

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

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Documentation reviewed by the assessors demonstrated that processes are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. Staff interviews and assessor observation of patient admission confirmed robust documentation. Variances are collated through RiskMan and reported via the NSQHS Standard 5 & 6 - Comprehensive Care and Communicating for Safety Committee through HPH Committee structure.
Rating
Met
Findings
-

Action 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Evidence Reviewed
Initial Assessment: Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care. Final Assessment: Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.
Rating
Met with Recommendations
Findings
Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.

Action 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Evidence Reviewed
Initial Assessment: Consumers have an opportunity to be involved with the clinical care and decision-making through pre-admission, admission and discharge procedures and consumer feedback mechanisms which are recorded in the RiskMan system. Evidence provided and observed by the assessors verified that the care planning process is patient centred and well documented. However, although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care. Final Assessment: Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.
Rating
Met with Recommendations
Findings
Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.

Action 5.15
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
HPH has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Assessors reviewed: Voluntary Assisted Dying (Tasmania) - 8.98d June 2023; Last Days of Life Care and Management - 8.96 July 2022; Advanced Care Directives - 2.56 July 2022 and Not for Cardiopulmonary Resuscitation (NFR), Management of Patients July 2022.
Rating
Met
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
HPH provide clinicians with access to specialist palliative care advice via the ICON Cancer Care Hobart Group.
Rating
Met
Findings
-

Action 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Evidence Reviewed
Advanced Care Plans received from patients are documented on the patient's health record
Rating
Met
Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Evidence Reviewed
HPH provides supervision and support for the workforce providing end-of-life care. HPH works very closing with the ICON Cancer Centre Hobart group located in close proximity to the hospital.

Rating
Met
Findings
-

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Evidence Reviewed
HPH has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care. These include (but not limited to), a Mortality Register which includes capturing data on the follow-up care with family, the development of a condolence card along with the Last Days of Life Policy, Folder and Toolkit.
Rating
Met
Findings
-

Action 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. The assessors reviewed Patient Brochures/Information including: Last Days of Life - Care Pack, Palliative Care Checklist - Understanding your Grief, A wish to go home, Last Days of Life Toolkit and Preparing for End of Life.
Rating
Met

Findings
-

Action 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Evidence Reviewed
There is provision for a skin assessment to be performed on admission and reviewed on discharge. Pressure injury incidents are reported in RiskMan and reviewed and monitored
Rating
Met
Findings
-

Action 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
Evidence Reviewed
Appropriate care and advice is given, with staff ensuring that the primary teams are aware of any compromise to skin integrity. Any pressure injuries are recorded in the RiskMan. Regular audits are built into the annual audit schedule.
Rating
Met
Findings
-

Action 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Evidence Reviewed
Staff have appropriate equipment available to them to aid in managing risks to skin integrity. Equipment, products and devices, including positioning gel pads and other positioning accessories, are available to prevent and manage pressure injuries, the assessor witness these products in use.
Rating
Met
Findings
-

Action 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Evidence Reviewed
All patients are assessed on admission against a standardised screening tool. Incidents are reported into RiskMan and data related to falls is analysed and reported via the NSQHS Standard 5 & 6 - Comprehensive Care and Communicating for Safety Committee through HPH Committee structure.
Rating
Met
Findings
-

Action 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
Evidence Reviewed
All patients are assessed on admission against a standardised screening tool. Those patients that are identified as a falls risk are managed as per Falls Prevention and Management - Patient 8.04 policy. All falls are reported into RiskMan and data related to falls is analysed and reported via the NSQHS Standard 5 & 6 - Comprehensive Care and Communicating for Safety Committee through HPH Committee structure.
Rating
Met
Findings
-

Action 5.26
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Evidence Reviewed
Information is available to patients, their carers / families about falls prevention and risk management strategies.
Rating
Met
Findings
-

Action 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice

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

Action 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Evidence Reviewed
Patients’ nutritional and hydration requirements, preferences, allergies and special dietary needs are identified and assessed on admission.
Rating
Met
Findings
-

Action 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

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

Action 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Evidence Reviewed
HPH has implemented processes for recognising, and managing patients with cognitive impairment, with instructions to prompt nursing staff when to seek further medical assessment incorporated into the pre-admission and patient registration form.
Rating
Met
Findings
-

Action 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide

c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

Evidence Reviewed

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

Rating

Met

Findings

-

Action 5.32

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

Evidence Reviewed

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

Rating

Met

Findings

-

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression

Evidence Reviewed

HPH has procedures in place to take action on behalf of a patient/other who is presenting as aggressive or at risk of harm to themselves or others, as per

Rating
Met
Findings
-

Action 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
Evidence Reviewed
Processes are in place to guide and support staff in the identification of situations that may result in aggressive behaviour, and how to manage them. Staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression are reported in the RiskMan. Assessors observed Emergency Procedures Flip Charts available near all phones and throughout the facility. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation. Staff undertake Healthscope - WAVE 1 - Managing Conflict & Challenging Behaviour training and education.
Rating
Met
Findings
-

Action 5.35
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body

Evidence Reviewed
Assessors reviewed Restrictive Practices - Patient Restraint (Non- Mental Health Facilities) 8.95 October 2019.
Rating
Met
Findings
-

Action 5.36
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body
Evidence Reviewed
HPH is not a gazetted hospital.
Rating
Not Applicable
Findings
-

Action 6.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication

Evidence Reviewed
Policies and procedures are in place to support effective clinical communication including handover. Patient Rounding 2.63 Aug 2022; Admission of Patient - Acute Medical/Surgical Hospital 2.65 Oct 2023; Correct Patient, Correct Procedure, Correct Site 2.15 July 2022; Discharge of a Patient 2.50 July 2022; and Discharge of a Patient - Against Medical Advice 2.51 Aug 2020. These policies identify risk management strategies and also the training requirements of all staff in support of effective clinical communication. Assessors viewed supporting documentation and witnessed various processes related to clinical communication.
Rating
Met
Findings
-

Action 6.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Evidence Reviewed
Incidents relating to failure in clinical communication are reported through RiskMan and identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover is monitored through feedback and audit.
Rating
Met
Findings
-

Action 6.03
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
HPH has procedures and policy that support the engagement of patients, their carers and families in their own care and shared decision making process. Patients are involved in clinical handover and verification of this was witnessed by the assessors. Patients who were interviewed (UR #375388 and UR #927065) reported being engaged in their care and that they had adequate information available to them to make informed decisions about their care.
Rating
Met
Findings
-

Action 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Evidence Reviewed
Policies and processes are in place to support staff use the appropriate identifiers when procedure matching, transfer of care, handover, discharge and where changes in clinical care/patient risk profile are identified. Documentation viewed by the assessors supports the use of specified identifiers in these situations. Documentation as per 6.01.
Rating
Met

Findings
-

Action 6.05
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
Evidence Reviewed
HPH has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the assessors verified this when observing clinical handover (refer to patient episode). Medical records (MRN reviewed during the final assessment confirmed that patients three identifiers were on all documentation including (but not limited to) consent for medial and/or surgical treatment and registration forms.
Rating
Met
Findings
-

Action 6.06
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care
Evidence Reviewed
The assessors noted the use of approved patient identifiers throughout the facility during the assessment. Additionally, processes are in place for surgical/procedural time-out, this is documented, audited and these processes were verified by the assessment team during observation of team "time out" in theatre. In the maternity ward, two arm bands are applied to babies prior to leaving the delivery room (theatre or labour ward) during the assessment it was verified that these bands are reconciled with the mother at the time of clinical handover. There is also a Theatre Time Out Audit scheduled on the National Audit Schedule, with results noted to be consistently high (97% 2022 and 95% in 2023).

Rating
Met
Findings
-

Action 6.07
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover
Evidence Reviewed
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient as well as the clinicians involved in the handover. Compliance with these requirements is audited and reported via the NSQHS Standards 5 & 6 - Comprehensive Care and Communicating for Safety Committee . Staff interviewed could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover. The assessors observed clinical handovers throughout the facility and these confirmed the documented processes.
Rating
Met
Findings
-

Action 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient

f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Evidence Reviewed

Initial Assessment: Although there are processes to document and evaluate Goals of Care in the medical record, this process is yet to be fully implemented. Healthscope corporate services are in the process of updating all obstetric medical records with a working party in place. The current care plans sighted in the medical records have no provision to document goals of care.

Final Assessment: Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.

Rating

Met with Recommendations

Findings

Healthscope corporate have updated all obstetric medical records to now facilitate the documentation of Goals of Care in line with other areas of the HSO, sufficient evidence for this action to remain as a Met with Recommendations. However, as documenting, communicating and evaluating Goals of Care for all patients including paediatric and obstetric patients is a relatively new process, this action is not fully implemented.

Action 6.09

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Clinicians who can make decisions about care

b. Patients, carers and families, in accordance with the wishes of the patient

Evidence Reviewed

HPH has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Clinical handover involves patients, their carers and families as required. Clinical handover is audited, and incidents/feedback related to communication issues are addressed appropriately.

Rating

Met

Findings

-

Action 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Evidence Reviewed
Documentation reviewed verified that there are communication processes in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients/carers interviewed confirmed this process and the assessors observed information available to support and facilitate this process, including " Hobart Private Hospital - Rapid Response Systems for Patients, Carers and Families - Addressing your concerns is as easy as 1,2,3 " posters observed in all patient rooms and throughout the hospital.
Rating
Met
Findings
-

Action 6.11
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan
Evidence Reviewed
Clinical documentation reviewed by the assessors confirmed compliance with the organisation’s process to ensure complete, accurate and up to date information and the recording of this in the patient healthcare record.
Rating
Met
Findings
-

Action 7.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Evidence Reviewed
The requirements of this action are well supported by the management at HPH through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards support clinicians to deliver blood management.
Rating
Met
Findings
-

Action 7.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Evidence Reviewed
Blood management is defined and monitored with a wide range of quality improvement strategies in place. Regular reporting occurs through the NSQHS Standard 7 - Blood Safety Committee with escalation to the highest governance as required. The organisation uses feedback, data and outcomes together with evidence based practice to support improvements in blood management.
Rating
Met
Findings
-

Action 7.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Initial Assessment: Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this and patients reported that they felt actively involved and informed about their care. However, in the small sample of medical records sighted during the review, processes to ensure consistent use of the Blood Consent is not fully implemented. Final Assessment: Although an immense amount of education, communication and auditing was evidenced at the final assessment regarding the processes for ensuring correct documentation is completed regarding blood and blood products, the sample of medical records reviewed by the assessment team verified that these processes are not yet fully implemented. However, there was sufficient evidence for this action to remain as a Met with Recommendations and not escalate. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.
Rating
Met with Recommendations
Findings
Although an immense amount of education, communication and auditing was evidenced at the final assessment regarding the processes for ensuring correct documentation is completed regarding blood and blood products, the sample of medical records reviewed by the assessment team verified that these processes are not yet fully implemented.

Action 7.04
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Evidence Reviewed
Clinicians are supported by policies and procedures to establish safe and effective blood management practices. Blood Fridge Management and Unused Blood Products - 8.64a, Blood Transfusion (Emergency) of Unmatched Red Cells - 8.63, Blood Transfusion - Management of Patient, Blood and Blood Products - 8.64, Blood Transfusion - Massive - 8.62 and Jehovah's Witnesses and Blood Transfusions - 8.87.

Rating
Met
Findings
-

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

Action 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Evidence Reviewed
HPH has processes and procedures in place to support clinicians in the safe and appropriate practice of prescribing and administering blood and blood products.
Rating
Met
Findings
-

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

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

Action 7.09
The health service organisation has processes: a. That comply with manufacturers' directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Evidence Reviewed
HPH has processes in place to comply with manufacturers directions and be able to trace blood and blood products from entry into the organisation including blood fridge temperature records and a blood register.

Rating
Met
Findings
-

Action 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Evidence Reviewed
HPH has process in the place to manage the availability, eliminate waste and respond in times of shortage through The Royal Hobart Hospital pathology which is co located.
Rating
Met
Findings
-

Action 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Evidence Reviewed
HPH has policies and procedures in place to recognise and respond to acute deterioration and staff were able to describe their role on such events. Documentation reviewed by assessors includes: Clinical Deterioration- Recognising and Responding to 8.45 October 2022; Delirium and Cognitive Impairment Prevention and Management 8.94 July 2022; Anaphylaxis Management 8.88 July 2023; Advanced Life Support (ALS) - Adult 8.13 July 2022;

Cardiac Surgical Advanced Life Support (CALS) 8.60 October 2022. Risks and training needs are discussed, monitored and identified via the NSQHS Standard 8 - Recognising and responding to Acute Deterioration - Clinical Deterioration Committee and training records were made available to the assessors.

Rating

Met

Findings

-

Action 8.02

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

a. Monitoring recognition and response systems

b. Implementing strategies to improve recognition and response systems

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

Evidence Reviewed

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration, the National Consensus Statement: Essential elements for safe and high-quality end-of-life care, the National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state and the Delirium Clinical Care Standard.

Rating

Met

Findings

-

Action 8.03

Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed
HPH has documents that were reviewed to show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. HPH consent to treatment process includes involving patients, meeting their information needs and shared decision making. The assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients. Assessors observed "Hobart Private Hospital - Rapid Response Systems for Patients, Carers and Families - Addressing your concerns is as easy as 1,2,3 " posters in patient rooms and on walls around the facility.
Rating
Met
Findings
-

Action 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
Evidence Reviewed
Initial Assessment: There are policies and processes to support the documentation of vital signs with the use of appropriate track and trigger charts throughout the facility, however, on review of medical records by the assessors the process of graphically documenting and tracking changes on the observation chart is not fully implemented. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation / intervention as per Clinical Deterioration- Recognising and Responding to 8.45 October 2022. Final Assessment: Although there was evidence of education, communication and auditing around the appropriate graphical documentation of observations (including joining the dots) and an improvement was noted by the assessment team, this process is not yet fully implemented. However, sufficient evidence for this action to remain as Met with Recommendations and not escalate. Medical records reviewed at the final assessment included UR# 321887; UR# 194970; UR# 988268; UR# 986073; UR# 162843 UR# 377147; UR# 376951; UR# 375707; UR# 121672; UR# 972335; UR# 955823; UR# 313507 and UR# 347370.
Rating
Met with Recommendations

Findings
Although there was evidence of education, communication and auditing around the appropriate graphical documentation of observations (including joining the dots) and an improvement was noted by the assessment team, this process is not yet fully implemented.

Action 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Evidence Reviewed
Policies and procedures support staff in identifying acute deterioration in mental state including the risk or delirium: Clinical Deterioration - Recognising and Responding to 8.45 October 2022 and Delirium and Cognitive Impairment Prevention and Management 8.94 July 2022. HPH clinical pathways documentation reviewed by assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration and/or delirium. Clinical documentation is audited regularly for compliance with documentation of any acute deterioration. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members. The requirements if Advisory AS 19/01 have been met.
Rating
Met
Findings
-

Action 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state

c. Agreed parameters and other indicators for calling emergency assistance

d. Patient pain or distress that is not able to be managed using available treatment

e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

Evidence Reviewed

HPH monitors performance of the identification and management of acute physiological, mental status, pain and/or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, RiskMan incident management and clinical review. Staff interviewed were aware of these processes and able to describe them to the assessors, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice.

Rating

Met

Findings

-

Action 8.07

The health service organisation has processes for patients, carers or families to directly escalate care

Evidence Reviewed

Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Assessors observed "Hobart Private Hospital - Rapid Response Systems for Patients, Carers and Families - Addressing your concerns is as easy as 1,2,3 " posters in patient rooms and on walls around the facility.

Rating

Met

Findings

-

Action 8.08

The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance

Evidence Reviewed
HPH policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and assessors were provided with documentation to support the evaluation of these processes.
Rating
Met
Findings
-

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

Action 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. HPH provides Basic Life Support training annually as it is a mandatory requirement for all clinical staff.
Rating
Met

Findings
-

Action 8.11
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. HPH provides Basic Life Support training annually as it is a mandatory requirement for all clinical staff and offer Advanced Life Support and PALs/Resus4kids training for those staff that require this additional competency.
Rating
Met
Findings
-

Action 8.12
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
Evidence Reviewed
All HPH patients are screened on admission to identify any psychosocial/delirium concerns, with management plans developed and monitored for patient safety. HPH has processes in place to ensure timely referral to mental health services for patients whose mental state has acutely deteriorated. The requirements of Advisory AS 19/01 have been met.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Evidence Reviewed
HPH policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to assessors. Assessors reviewed Clinical Deterioration - Recognising and Responding to 8.45 October 2022.
Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable