National Safety and Quality Health Service Standards 2.1 Short Notice Assessment
Final Report

Nepean Private Hospital

PENRITH, NSW

Organisation Code: 120314
Health Service Facility ID: 100980
ABN: 85 006 405 152
Assessment Date: 12-14 August 2024

Accreditation Cycle: 2

Contents

Introduction

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

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

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

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

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

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

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

The Commission works in four priority areas:
1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme

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

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

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

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

Org Name   :   Nepean Private Hospital
Org Code   :   120314

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Deborah Lewis	Yes
Lead Assessor	Heather Brown	Yes
Assessor	Paula Elliott	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Nepean Private Hospital. The accreditation decision was made on 19/09/2024 and Nepean Private Hospital was notified on 19/09/2024.

How to Use this Assessment Report

The ACHS assessment report provides an overview of quality and performance and should be used to:

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

The Ratings:

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

A rating report is provided for each health service facility.

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

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

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

Suggestions for Improvement

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

Recommendations

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

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

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

Executive Summary

Nepean Private Hospital underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 12/8/2024 to 14/8/2024. The NS2.1 Short Notice Assessment required three assessors for a period of three days. Nepean Private Hospital is a private health service and was last assessed between 9/11/2021 and 11/11/2021.

The ACSQC PICMoRS methodology was used to conduct this assessment, with approximately 75% of assessor time spent in operational areas during the assessment.

Nepean Private Hospital (NPH) is a 109-bed acute care Hospital which is co-located with Nepean Hospital (NH). NPH is part of the Healthscope group of hospitals, and in 2023 it underwent a major redevelopment which expanded the peri-operative area including a new CSSD and a Day of Surgery Centre. During the assessment, the Hospital demonstrated that the clinical governance framework is effectively used to monitor and improve the safety and quality of clinical care.

All staff, including VMOS, undertake orientation upon appointment to NPH. Training includes a one-hour session on quality and safety that is focused on the expectations of the individual, compliance with policy and mandatory training. Education is promulgated to NPH from the Healthscope national education team. Cultural awareness and cultural training of the workforce to meet the needs of Aboriginal and Torres Strait Islander patients is mandated for all staff. There are robust processes for performance review, including setting individual goals, future education needs and opportunities to progress careers at NPH.

Credentialling is consistent with legislative requirements and is closely monitored for compliance with scope of practice, and recredentialling for all clinicians.

Best practice guidelines include care pathways, clinical risk assessment, clinical care standards and action plans to meet the NSQHS advisories. Variations in clinical practice, and morbidity and mortality data are monitored via the craft groups and MAC.

Strong leadership guides staff and consumers in a collaborative approach to safety and quality, evident in the improvements identified during the assessment. Incident reporting uses the electronic RiskMan platform and reports are submitted through the governance structure for discussion and analysis. Cultural diversity is appreciated and orientation, mandatory and ongoing education is provided to staff to meet consumer expectations and reflect the vision of NPH. Strategies and processes are in place to enhance partnering with Aboriginal and Torres Strait Islander people through representation on the internal committees and links to the local Aboriginal association. All staff interviewed during assessment demonstrated a genuine commitment to safety, quality and patient care.

Partnering with consumers is a key focus for NPH and it closely monitors the Net Promoter Score and patient feedback to identify any opportunities for improvement. Governance of financial and clinical consent is consistent with regulatory requirements. Patients felt well informed of their treatment plans and engaged in decisions about their care. The Charter of Healthcare Rights is readily available. Consumers are actively involved in the governance of the hospital and are involved in the design, measurement and evaluation of the care delivered to patients. Consumers are given training to support them in their role. The hospital works with the local Aboriginal and Torres Strait Islander communities to meet their healthcare needs.

The hospital uses HICMR policies and procedures, mandatory and continuous training, tool kits, and risk assessments provide evidence-based care and processes to effectively manage infection prevention and control, in close liaison with the IPC Coordinator and Committee. Governance of antimicrobial stewardship is robust and compliant with best practice. Hospital-acquired infections, and staff exposures to blood and body fluids are minimal. Incidents are documented in RiskMan and promptly actioned via eQuaMS.

Compliance with hand hygiene is better than the national average, and this achievement has been recognised by Healthscope Corporate. Furthermore, close attention is paid to aseptic technique. Healthscope Corporate has a rigorous process to evaluate and implement new invasive devices.

and the assessment team noted the performance of the environmental cleaning and maintenance staff who ensure that the hospital is clean, well maintained and presents well to the consumer. The refurbished CSSD and Endoscopy suite are impressive, and the facility is complemented by staff whose achievements in providing best practice care and management of reprocessed reusable devices are noted. Traceability of reusable items is robust, and this will continue to improve as the electronic tracking system is implemented across the hospital.

NPH can be commended for assisting with the demand for local aged care services during the Covid pandemic. This demonstrated the overall positive culture of the organisation, willingness, and flexibility to provide services during exceptional and unexpected circumstances.

This area is well covered by appropriate and up to date policies and procedures which were known to and adhered to by staff. Documentation is well done and all legislative requirements for prescribing, dispensing and administration are covered. The introduction of WebPAS linking the contracted pharmacy to NPH has enhanced the role of the Clinical Pharmacist and ensured that appropriate timely medication discussion with the patients.

There is an organisation wide and systematic approach to the delivery of comprehensive care which is multidisciplinary and supports clinicians to develop, document and communicate comprehensive plans for patients' care and treatment.

Clinical risk assessment is managed according to best practice guidelines and policy directives, training, and competency assessment. Compliance is monitored via audits and outcomes are reported at the clinical units and via the system of clinical governance. Pressure injuries were reported to be zero, and improved management of the risk of falls is resulting in a downward trend. Incidents of aggression are rare and mostly reported as low risk. Nutritional assessment is assessed with referral to a dietitian and appropriate allied health services as required. The multidisciplinary review of the cardiac patients' diet has been effective with the introduction of a low salt diet. Physical restraint is not approved and there were no reported incidents of restraint at the site visit. Low dose chemical restraint is tightly controlled and only used in collaboration with consent from the family or carer.

NPH is complaint with AS 19/01, Recognising deterioration in a person's mental state, and AS 22/01, Delirium Clinical Care Standard. The NPH delirium working party has been effective in mitigating the risk of delirium postoperatively, through risk assessment and referral to a geriatrician for appropriate planning prior to admission. As NPH does not provide psychiatric services seclusion is not applicable.

The organisation's compliance with policies to use three approved identifiers of patients at admission, transfer of care, and at administration of treatment was evident. Observation and documentation of 'Time Out' in the operating theatres is consistent with best practice.

Huddles, handover, the patient care boards, and 'REACH' encourage participation and shared decision-making with patients, families and carers. This was observed in a variety of clinical settings, and patients confirmed their satisfaction with communication.

The ISOBAR system provides the structure for clinical handover, and a recent improvement is the quality action plan to monitor handover by the Career medical Officers (CMOs).

There is evidence that NPH has systems and processes to ensure the safety of the patient throughout their journey if they require blood products. Staff are trained in blood management, have access to best practice guidelines, policies and tools to support them in the provision of blood and blood products. Clinical documentation captures the clinical information required, including past transfusion history, blood and blood products used, patient consent and patient observations. Strategies are in place to reduce blood usage and prevent blood wastage. The Hospital reports that there have been no incidents reported for blood management.

NPH uses Healthscope and local policies and procedures to support the recognition and response processes for the deteriorating patient. Policies are consistent with the 'National Consensus Statements for physical deterioration, high-quality end-of-life care and mental state deterioration' as well as the 'Delirium Clinical Care Standard'. Patient deterioration is well-managed with all patient incidents recorded, managed, investigated and analysed for improvement opportunities. REACH signage is displayed across the facility showing how patients and families can escalate care with the process explained to all patients on admission and further information provided in patient information at the bedside. Staff are trained in Basic Life Support (BLS) and Advanced Life Support (ALS), and a Medical Emergency Team (MET) responds to critical medical emergencies with a CMO, available at all times. Emergency trolleys are located in each area, are appropriately stocked and regularly checked for completeness. Appropriate risk identification and responses and mitigation policies and procedures have been developed as evident in the Risk Register. Information on the minimisation of exposure to clinical risks is readily available for patients and families.

Summary of Results

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

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

Org Name   :   Nepean Private Hospital
Org Code   :   120314

Sites for Assessment
Nepean Private Hospital

Site	HSFID	Address	Visited	Mode
Nepean Private Hospital	100980	1-9 Barber Ave, KINGSWOOD NSW 2747	Yes	On Site

Contracted Services

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

Provider	Description of Services	Verified During Assessment
Spotless Linen (corporate)	Linen services	Yes
BGIS	Maintenance and Fire	Yes
Penrith Sports Physiotherapy	Physiotherapy	Yes
Cleanaway Daniels	Clinical Waste	Yes
Initial	Sanitary Waste	Yes
Nepean Diagnostics	Radiology	Yes
TRESS	Security	Yes
Otis	Lift repair	Yes
Invitro	Steriliser repairs	Yes
HICMR	Infection Prevention and Control	Yes
SC Medical	Biomedical Equipment testing	Yes
Integra	Water Treatment	Yes
Omnivision	Security and Access Control	Yes
Hobart	Food service equipment repairs	Yes
Dishtec	Food services equipment repair	Yes
Core Gas	Bulk Oxygen	Yes
Sharp Cooling	Blood fridge Maintenance	Yes
Phillips	Cath lab equipment	Yes
BIJIB	CMOs	Yes
HPS	Pharmacy	Yes
Barrat and Smith	Pathology	Yes
Pathology West	Pathology	Yes
Clinical Labs	Pathology	Yes
NBMLHD	Training - Advanced Life Support	Yes

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

Standard 1 - Clinical Governance

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

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
The governing body provides leadership to develop a culture of safety and quality improvement and conducts regular culture surveys to monitor this. The Strategic Plan includes safety and quality objectives. A Committee Structure provides oversight of the safety and quality performance of the Hospital. Systems and processes support NPH in capturing the information required to monitor its safety and quality performance, with the information on key safety and quality measures reported through the Committee Structure up to the governing body. Leadership is provided to ensure partnering with patients, families and carers with the Net Promotor Score providing a key measure of how well they are doing in meeting consumer needs. Training is provided to the workforce, including the Board, to ensure that they understand the roles and responsibilities for safety and quality. The Board has endorsed the 2024 – 2025 Clinical Governance Plan.

Rating	Applicable HSF IDs
Met	All

ACTION 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Comments
The Leadership team described how the specific health needs of Aboriginal and Torres Strait Islander people are being addressed, with an action plan outlining the strategies to achieve this. A large number of patients have not identified if they are Aboriginal or Torres Strait Islander or other. This has led NPH to focus on creating a welcoming environment and providing training to staff on cultural competency to create a culturally safe environment for Aboriginal and Torres Strait Islander patients so that they feel safe identifying and can then be connected to appropriate services to provide them with cultural support whilst an inpatient at the Hospital. NPH meets the requirements of Advisory AS18/04.

Rating	Applicable HSF IDs
Met	All

ACTION 1.03
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
Comments
A clinical governance framework, aligned to the Strategic Plan, consists of eight key pillars: leadership and culture, people and partnerships, clinical data and outcomes, managing risk, quality improvement, evidence-based practice, staff capability building and patient experience. Systems and processes are in place to monitor the performance of each of these pillars and guide NPH in providing safe and quality services. Evidence provided by NPH showed that these systems and processes are being used effectively to monitor the performance of the Hospital.

Rating	Applicable HSF IDs
Met	All

ACTION 1.04
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
Comments
NPH has strategies to monitor the effectiveness of the quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people. Audits of administrative data are conducted to determine whether there has been an increase in the percentage of Aboriginal and Torres Strait Islander patients who are identifying since action has been taken to improve the environment to make it more welcoming and engaging with Aboriginal Health Services and the local Aboriginal Community to improve access to culturally appropriate care. Completion of cultural competency training is monitored. The service has strategies to improve employment outcomes by increasing Aboriginal and Torres Strait Islander recruitment, retention and development and by providing culturally appropriate ways for employees to self-identify as Aboriginal and Torres Strait Islander people.

Rating	Applicable HSF IDs
Met	All

ACTION 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Comments
the service provided examples of patient safety and quality issues being considered when making business decisions with. The Clinical Services Plan outlines plans for current and future services, taking into account location, infrastructure requirements and the resources required to support them. The Capital and Master Plan is used to budget for long term plans and includes consideration of patient safety and quality issues in the decision-making process.

Rating	Applicable HSF IDs
Met	All

ACTION 1.06
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients
Comments
A survey is used to monitor the safety culture within the hospital and action plans are developed in response to the findings where opportunities for improvement are identified. Committee minutes and safety and quality reports demonstrated that clinicians operate within the clinical governance framework. Clinicians demonstrated that they understood their safety and quality roles and described the various aspects of clinical governance, such as incident and complaint management processes.

Rating	Applicable HSF IDs
Met	All

ACTION 1.07
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Comments
Policies and procedures which address the requirements of the National Standards are available to the workforce. Policies are referenced, meet legislative and regulatory requirements and are monitored for currency. Document management processes include a review and authorisation process. Audits are conducted to monitor compliance with policies and procedures and action plans developed where targets are not met

Rating	Applicable HSF IDs
Met	All

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

Comments
NPH uses an organisation-wide quality improvement system to identify safety and quality measures and monitor and report performance and outcomes. Training is provided to staff to support them in understanding the principles of safety and quality. NPH uses eQuaMS which is a repository of data collected through various safety and quality systems, action plans developed in response to findings and outcomes arising from actions undertaken. The Executive and Board Quality Key Performance Indicator (KPI) report is a monthly report on safety and quality performance indicators including patient incidents, including sentinel events complaints, patient rated experience (net promoter score), Hospital-Acquired Infections etc. A gap analysis against the National Standards provides a map of actions needed to meet the Standards

Rating	Applicable HSF IDs
Met	All

ACTION 1.09
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations

Comments
KPIs are reported on a monthly basis and included in the Executive and Board Quality KPI report. This information is reported locally to the Medical Advisory Council, the Executive Committee, the Patient Safety and Quality Meeting and Craft Group Committee Meetings. Quality Boards display KPI information at the ward level for the workforce and patients and their families to see. Team meetings also discuss results for their specific service.

Rating	Applicable HSF IDs
Met	All

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Comments
NPH policies guide the identification and management of risks. Risks are identified through a range of mechanisms and are documented in the RiskMan risk register. The risks are trended and prioritised based on rating, and risk management plans are monitored for their effectiveness in reducing the level of risk, with the management of risks assigned to the relevant manager. Frontline staff described local risks associated with their service and outlined mitigation strategies to reduce the level of risk, showing a good understanding of risk management principles. A business continuity plan is in place.

Rating	Applicable HSF IDs
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
NPH uses RiskMan as its incident management and investigation system, and staff have training in incident management. Quality Boards are displayed prominently in each clinical area and include information on incidents that have occurred in that area, such as falls. This information is for staff, patients, and families to view. Incidents are rated, trended and categorised in terms of incident type, location, and time, with this information used to identify opportunities for improvement and identify emerging risks. All incidents are investigated, with a root cause analysis (RCA) conducted on all serious incidents. Incident data is included in the safety and quality report and monitored through the clinical governance committee structure

Rating	Applicable HSF IDs
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
An Open Disclosure Policy guides clinicians in their response to adverse events and complaints, with NPH expecting open disclosure to be conducted in an open, honest and consistent way. Clinicians have training in open disclosure to support them in undertaking this task, and there is a system for monitoring that open disclosure was conducted and who led the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
NPH collects patient feedback regularly collected and this is highly valued in providing the service with the information they need to evaluate patients' experiences and to identify opportunities for improvement. The Net Promoter Score is monitored with a target score of over 85. Data showed that tracking of the score is conducted over time with staff describing the actions taken to improve the net promoter score.	
Rating	**Applicable HSF IDs**
Met	All

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

Comments
A Complaints Management Policy guides the management of complaints at NPH, with the Quality Manager responsible for managing complaints made by patients and their families All complaints are investigated and receive a response, and are documented in RiskMan, with complex complaints escalated to the Director of Clinical Risks and Patient Safety. Complainants are informed of their right to refer their complaint to the Health Care Complaints Commission. KPIs on complaints are reported through the Committee structure and up to the Patient Safety and Quality meeting, the Medical Advisory Committee and relevant craft groups and team meetings as well as to the Safety and Quality Committee, which is a sub-committee of the Board. KPIs include the time frames to responding and resolving complaints and complaints by classification and service.

Rating	Applicable HSF IDs
Met	All

ACTION 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care

Comments
Administrative data is used to identify the demographics of health service users and is used for service planning and delivery. Data shows a high percentage of patients are English speaking with other cultural groups identified. The percentage of Aboriginal and Torres Strait Islander people living in the community is higher than the percentage receiving care at NPH and the focus on increasing the percentage by creating a welcoming environment and increasing the cultural competency of the workforce is a key strategy for the service. The age of patients admitted is also used to assist in service planning and delivery.

Rating	Applicable HSF IDs
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
A paper healthcare record is available to clinicians at the point of care and all staff are trained in its use, which includes information on privacy and confidentiality. Audits are conducted regularly to monitor documentation and other aspects of healthcare record management. Healthcare records are stored securely. A privacy policy guides the use of patient information and patients are informed about how NPH uses the information collected. Risks associated with the healthcare record have been identified and included in the risk register and are regularly monitored to ensure they are being managed effectively.

Rating	Applicable HSF IDs
Met	All

ACTION 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Comments
The Hospital has completed a gap analysis and has a plan in place for implementing systems that can provide clinical information into the My Health Record system. The IT service manages the WebPAS system across Healthscope and national patient and provider identifiers and standard terminologies are in place. The Nursing Discharge summary is scanned into MHR as it is a paper form. The Forms/Health Information Committee is monitoring the implementation and use of the My Health Record system. The Hospital meets the requirements of Advisory AS18/11.

Rating	Applicable HSF IDs
Met	All

ACTION 1.18
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system
Comments
The My Health Record policy guides the provision of clinical information into the My Health Record system, and the recruitment of an eHealth coordinator to undertake training and have access to the system is underway. There are processes to monitor the accuracy and completeness of the nursing discharge summary which is uploaded in the MHR. The service is confident this will all be in place to meet the timeframe outlined in the Advisory.

Rating	Applicable HSF IDs
Met	All

ACTION 1.19
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
Comments
Position descriptions, policies and the Healthscope By-Laws describe roles and responsibilities for all employees and contractors who are required to complete orientation and induction to the workplace.

Rating	Applicable HSF IDs
Met	All

ACTION 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
Comments
All staff are required to complete orientation and mandatory training that address the requirements of the national standards. Individual compliance and competency assessment is linked to performance review. Data on compliance with mandatory training is tracked by unit managers, the education team, governing committees, and reported on unit-based quality boards.

Rating	Applicable HSF IDs
Met	All

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
The partnership with Merana Aboriginal Community Association is integral to mandatory cultural competency training, for all staff. A summary of the data collected from patients identifying as Aboriginal or Torres Strait Islander is very good. In addition to artwork, there is work in progress to identify way finding with Aboriginal murals, designed by a local artist. There is an action plan to underpin the First Nations Peoples' Engagement Plan 2024 – 2026.

Rating	Applicable HSF IDs
Met	All

ACTION 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Comments
Performance reviews are conducted annually, and staff are engaged in the process and encouraged to identify training and educational needs. This is used as an opportunity to develop future leaders for succession planning. The quality boards and frequent huddles in the clinical units, combined with departmental educators, facilitate the timely and appropriate development of quality and safety. The initiatives to train midwives in collaboration with the co-located Nepean Hospital and with universities is impressive, and there has been an excellent response to this initiative.

Rating	Applicable HSF IDs
Met	All

ACTION 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Comments
The Healthscope corporate policy for 'Accredited Health Practitioners Credentials' Was noted, and there are extensive by-laws for the accreditation of medical practitioners, including application for re-accreditation. The Medical Advisory Committee (MAC) credentialling committee ensures that all surgeons and colonoscopists maintain three yearly certification from the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy. Compliance and scope of practice is closely monitored by the Director of Nursing. Processes are in place for introduction and credentialling of new technology (e.g. robotic surgery).

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
Robust processes for regular reaccreditation of medical practitioners were observed, and APHRA registration for nurses is monitored weekly and monthly, and audited. No clinical practitioners employed with restrictions on scope of practice at the time of the assessment. The allied health services are contracted. Bookings for surgery ensure appropriate credentialling and scope of practice via WebPAS. A recent quality improvement to the credentialling process involves checking and confirming the credentialled status of surgical assistants well in advance of surgical lists.

Rating	Applicable HSF IDs
Met	All

ACTION 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Comments
NPH has an extensive annual audit and action plan for Quality and Safety encompassing access to resources on the hospital internet, patient satisfaction, input from consumer consultants, education, access to minutes of meetings, compliance with KPIs, resources for Aboriginal or Torres Strait Islander patients, awareness of national standards, risks, performance appraisal and engagement in quality activities. Job descriptions outline safety and quality roles for all staff. The April 2024 Quality and Safety audit shows increased compliance from 66% in 2023 to 75%.

Rating	Applicable HSF IDs
Met	All

ACTION 1.26
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Comments
There is always a representative from the Executive on duty, with access to an Executive staff member who is on call after-hours. CMOs and nursing staff are well informed of escalation processes to the VMO after hours.

Rating	Applicable HSF IDs
Met	All

ACTION 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Comments
Clinical care standards are available to all clinicians online and it was noted that all clinical advisories from the ACSQHC have a supporting action plan for implementation. NPH uses Healthscope's evidence-based clinical pathways and risk assessment tools. Joint replacement data is submitted to that National Joint Registry. An action plan was developed to implement the Colonoscopy Clinical Care Standard, AS18/12, under the clinical governance of the Physician Committee. The organisation is compliant with AS18/12.

Rating	Applicable HSF IDs
Met	All

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system

Comments
Morbidity and mortality, incidents, variations in clinical care, and patient feedback are discussed at the relevant multidisciplinary craft group meetings reporting to the MAC. Clinical incidents and variations in care are reported via RiskMan. Action plans are developed in RiskMan. Clinical indicators are submitted to ACHS, and outliers requiring improvement have an action plan in place.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
A review of safety and quality documentation showed that the preventative and reparative maintenance of buildings, plant, equipment, utilities, devices, and other infrastructure is undertaken to ensure that they are fit for purpose. Safety of the environment is considered in service planning and design. Maintenance is outsourced by Healthscope corporate office with ready access to all trades and an extensive Preventative Maintenance Program in place. The new build opened since the last assessment was well planned and purpose-built. Biomedical equipment is serviced by Biomedical Engineering, and testing and tagging and fire safety compliance is current. Body protection circuits are in place in all rooms where monitoring takes place, and generators are tested monthly. Thermostatic mixing valves (TMVs) are tested regularly, and legionella tests are conducted on TMVs and warm water system monthly with no positive results recorded. The review and upgrade of chemicals and dispensers in the cleaners' rooms reduces Work Health & Safety (WHS) risks and the removal of cloth string mops and the introduction of flat mops has been successful from an environmental and cleaners' safety perspective. The Emergency Management Plan ensures readiness for both internal and external emergencies, and codes are tested regularly, and evacuation exercises conducted routinely. The WHS Committee is active and well attended. Appropriately trained Fire Wardens are allocated to each shift. There is CCTV surveillance across the site with strategically placed duress alarms which are tested regularly. The staff demonstrated pride in maintaining a clean and comfortable environment.

Rating	Applicable HSF IDs
Met	All

ACTION 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Comments
While few incidents of aggressive behaviour have been recorded since the organisation opened the new build, a review has been undertaken to identify areas that are potentially high-risk for unpredictable behaviours, with processes to ensure that emerging risk areas can be appropriately identified and managed. Strategies have been developed to ensure that people are treated in appropriate areas and risks associated with unpredictable behaviours are considered through pre-admission and admission risk assessments. Processes and strategies are in place to minimise the risk of harm to consumers and staff by unpredictable behaviours with staff trained in de-escalation processes.

Rating	Applicable HSF IDs
Met	All

ACTION 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Comments
Internal and external directional signage is clear and fit for purpose, with some temporary signage in place to facilitate access to the new adjoining premises. Partnering and consultation has been undertaken with Merana Aboriginal Community Association to design and develop signage in the local language to be incorporated with Aboriginal designed wayfinding mural pathways.

Rating	Applicable HSF IDs
Met	All

ACTION 1.32
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
Comments
Flexible visiting arrangements are in place for most areas with some restrictions for maternity, palliative and end-of-life care if necessary. Patients reported satisfaction with visiting arrangement.

Rating	Applicable HSF IDs
Met	All

ACTION 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Comments
The organisation demonstrates a welcoming environment and recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people, with the local Merana Aboriginal Community Association guiding the development of a welcoming and comfortable environment. Commissioned artwork is clearly displayed as are large photographs of the local countryside. Wayfinding in local language is currently being designed.

Rating	Applicable HSF IDs
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
The Consumer Engagement Framework guides partnering with consumers. The safety and quality system captures risks associated with partnering with consumers through incidents, complaints, patient feedback and audit processes. Risks are managed through established HR processes including the identification of training requirements for consumer representatives, with a consumer representative outlining the training he has had as part of his role.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	
The Standard 2 Working Party monitors NPH's performance against the requirements of Standard 2. A gap analysis completed against the Standards drives the identification of areas for improvement with action plans developed to address these. Reporting on the performance of NPH against Standard 2 is part of the suite of measures reviewed through the governance structure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers
Comments
Patients are informed of their rights and responsibilities, consistent with the Australian Charter of Healthcare Rights, in the Patient Information Directory issued on admission and placed in patient rooms. Posters are located on notice boards.

Rating	Applicable HSF IDs
Met	All

ACTION 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Comments
The Healthscope Corporate policy, 'Consent to medical / surgical treatment' references national guidelines and relevant state legislation. Close monitoring of consent was observed in the operating theatres, including processes where a consent had not been obtained prior to admission to the theatre suite. Staff are well educated and know how to safely manage consent as per policy. Patients are informed of payment details in the Patient Information Directory. Obtaining informed financial consent was observed with advice available to patients regarding financial consent for clinical care.

Rating	Applicable HSF IDs
Met	All

ACTION 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Comments
NPH has processes for regular clinical risk assessment for delirium, cognition, and mental health. Polices and processes are also in place for a substitute decision-maker if the patient does not have capacity to make decisions, staff understood these processes.

Rating	Applicable HSF IDs
Met	All

ACTION 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Comments
The Healthscope corporate policy for Consent to Medical / Surgical Treatment outlines the processes to engage a substitute decision-maker. In the absence of a substitute decision-maker, processes are in place for Special Medical Procedures that require an application to the NSW Civil & Administrative Tribunal Guardianship Division for consent to make decisions about care. Consent is dependent upon a patients' legal capacity to make decisions about care. The policy outlines the specific requirements for children's consent.

Rating	Applicable HSF IDs
Met	All

ACTION 2.07
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care
Comments
Staff form partnerships with patients via regular rounding, handover, and use of the patient boards. Prompts such as 'goals of care' and 'what matters to you' encourage patient engagement. Furthermore, a reminder about REACH, 'Are you Worried?' on the patient boards encourages patients to speak up.

Rating	Applicable HSF IDs
Met	All

ACTION 2.08
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
Comments
Demographic information is used to identify consumers' communication needs with staff describing various ways that communication is tailored to the diversity of service users. Information collected on admission provides data on the languages spoken by patients admitted to NPH and this is flagged in the health care record. Interpreters are used as required, including Auslan interpreters. Midwifery staff adapt their language to support same sex parents using words such as birth partner. Communication through social media has also been effective in reaching patients. Pregnant Aboriginal women can attend antenatal education for Aboriginal people run in the community.

Rating	Applicable HSF IDs
Met	All

ACTION 2.09
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
Comments
Consumers are involved in developing and reviewing information about health and health services with a consumer representative describing his role in doing this. This information has a consumer tick to indicate that it has been reviewed which was noted during the assessment.

Rating	Applicable HSF IDs
Met	All

ACTION 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge
Comments
The service has structures in support clinicians in providing information to patients about their clinical care. This includes case conferences, ward rounds and clinical handover. Multidisciplinary team meetings provide a forum for clinicians to coordinate care. Care boards in patient's rooms are used to communicate care plans to patients and for patients and their families to use to communicate to the team. Patient feedback is used to monitor whether the information provided to patients meets their needs and whether the clinical needs of patients are addressed while they are in hospital. The Net Promotor Score is used as a key quality measure and is reviewed through the clinical governance structure and the Board. Key themes are reviewed, and action plans developed in response to findings. Patients are provided with a discharge summary on discharge.

Rating	Applicable HSF IDs
Met	All

ACTION 2.11
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
Comments
Consumers are involved in governance planning and evaluation of health care with a consumer representative describing activities he has been involved in at both the local and National level. Consumer representatives reflect the diversity of the local community.

Rating	Applicable HSF IDs
Met	All

ACTION 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Comments
Consumer representatives are oriented to the hospital briefed about safety and quality systems on commencing their role and. A consumer advisory pack has been developed by the National Consumer Advisory Group, with input by a consumer representative from NHP There is a mentoring program for new consumers to support them in their new role.

Rating	Applicable HSF IDs
Met	All

ACTION 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Comments
NPH works in partnership with the local Merana Aboriginal Community Associated to provide Indigenous Advisory Services. The service is able to access the Aboriginal Health Liaison Service in the co-located Nepean Hospital and is also active in engaging elders in cultural protocols. Artwork has been commissioned and hung in the main foyer to create a more welcoming environment for Aboriginal and Torres Strait Islander patients.

Rating	Applicable HSF IDs
Met	All

ACTION 2.14
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce
Comments
Consumer representatives on the Consumer Advisory Committee and the Standard 2 Committee described their role in educating staff about the patient experience. The Merana Aboriginal Community Associated will facilitate cultural awareness sessions for staff to get a shared understanding about the patient experience from an Aboriginal and Torres Strait Islander perspective. Sharing patient stories is another way the Hospital learns from the experience of its patients.

Rating	Applicable HSF IDs
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
NPH uses the Healthcare Infection Control Management Resources (HICMR) to provide to provide evidence-based and current policies and procedures for Infection Prevention and Control (IPC) which reference national and state guidelines. All policies are ratified by the IPC Committee and available to all staff online. A combination of extensive staff training, and regular auditing ensures compliance with policies. IPC training is regularly evaluated and improved by Healthscope in conjunction with HICMR. The most recent review streamlined the mandatory program to make it more user friendly. HICMR conducts annual IPC and antimicrobial (AMR) risk assessments that are actioned via a Risk Management Plan. Continuous risk assessments confirm whether the previous recommendations have been satisfactorily actioned. There is an AMS policy in place and data is submitted to the National Antimicrobial Prescribing Survey (NAPS). NPH is compliant with the intent of the Antimicrobial Stewardship Clinical Care Standard (2020).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
NPH monitors hospital-acquired infections, incidents, surveillance data, audits such as hand hygiene, aseptic technique via RiskMan. For the year to date, there have been no hospital-acquired SAB infections. Independent audits by the pharmacy service provide reports on Surgical Antibiotic Prophylaxis for Total Hip Replacement, Total Knee Replacement and LSCS. Overall compliance over the last four periods ranges from 90-100% for the criteria 'correct time', 'correct dose' and 'correct duration'. Outcomes are reported via the clinical governance system , including the craft group meetings. A comprehensive suite of audits from HICMR and Healthscope are used to monitor and ensure safe and sustainable use of infection control resources. The IPC Coordinator follows up on any identified gaps, and these are supported with action plans.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Comments
The hospital wide sharps collection audit 2024 is an example of a proactive quality improvement activity. Extensive data is collected on each clinical unit, presented for compliance with best practice. While the outcomes were compliant with best practice overall, minor recommendations were summarised for action. As noted previously, hospital-acquired infections, incidents, surveillance data and audits such as hand hygiene, aseptic technique are monitored. Independent audits by the pharmacy service provide reports on Surgical Antibiotic Prophylaxis for Total Hip Replacement, Total Knee Replacement and LSCS. Overall compliance over the last four periods ranges between 90 and 100% for the criteria 'correct time'. Correct dose' and correct duration. Outcomes are reported via the system of clinical governance, including the craft group meetings. Assessors noted the comprehensive suite of audits from HICMR and Healthscope used to monitor and ensure safe and sustainable use of infection control resources. The Infection and Prevention Control Coordinator follows up on any identified gaps, and these are supported with action plans. HICMR is a 24/7 resource.

Rating	Applicable HSF IDs
Met	All

ACTION 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
IPC information is available to consumers on the NPH website and in admission information, quality boards, NHMRC publications re infections such as MRSA, and signage in the hospital. Patients are screened at preadmission and at admission for infectious status. NPH provided examples of patients presenting with infection who were appropriately treated, accommodated, and counselled regarding their care and information needs to enable shared decision-making. The pharmacy service provides written and verbal information to patients regarding antimicrobials.

Rating	Applicable HSF IDs
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Comments
NPH has a process for the regular surveillance of surgical site infections, including hospital-acquired infections, such as staphylococcus aureus bacteraemia, MRSA and Clostridium difficile. At the time of the assessment there were no significant trends, and minimal infections were reported. RiskMan reports are reviewed as a standing agenda item at the IPC Committee. Antimicrobial use is reviewed as part of infection surveillance, and the outcomes of infection surveillance are reported and closely monitored by the craft groups, MAC and staff via staff meetings and safety huddles. Infection alerts are noted in WebPAS and referred to the relevant clinical staff from pathology for immediate action. IPC Data is available to consumers on the quality boards. A review of the ACHS Infection Control Clinical Indicators for the second half of 2023 shows NPH performs better than the Healthscope, General and Private Aggregate Rates for every indicator.

Rating	Applicable HSF IDs
Met	All

ACTION 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Comments
HICMR policies, procedures, and tool kits, consistent with the Australian Guidelines for the Prevention and Control of Healthcare, are promulgated through the hospital. Regular newsletters inform staff of updated procedures. There is extensive education and orientation regarding the correct use of PPE and fit testing. Registers are maintained for fit testing for staff and VMOs. HICMR risk assessment includes compliance with standard and transmission-based precautions. The user-friendly Quick Reference Guide for transmission-based precautions is a colour coded chart that matches correct use of PPE to infections is easily accessed.

Rating	Applicable HSF IDs
Met	All

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Comments
There are collaborative and consultative processes in place to assess and communicate the risk of infection, in conjunction with government authorities, Healthscope Corporate and HICMR. Risks are mitigated via mandatory training and updates according to emerging risks. There are regular audits, and observation of clinical and non-clinical staff compliance with standard and transmission-based precautions. Fit testing is in place.

The maintenance risks have been mitigated as per HICMR risk assessments and completion of recommended actions. There is a robust maintenance register in place. Patients are screened at preadmission and on admission for the risks of infection. There is a particular focus on screening orthopaedic patients at preadmission and assessing risks at antenatal classes. Planning for admissions includes review of alerts and appropriate placement of patients. |

Rating	Applicable HSF IDs
Met	All

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Comments
Communication regarding risks of infection is noted on the medical record on admission, handover, and transfer of care. Most of the patient rooms are single occupancy, with ensuite bathrooms, so all patients identified as infection transmission risks are easily allocated to a private room. Appropriate equipment is provided for PPE and routine care and there are processes in place to manage the well-being of the patient in isolation. Water testing, cooling towers, heating and ventilation are regularly tested and monitored and were reported to be within normal parameters. Effort has been made to maintain the integrity of the older parts of the hospital, including the replacement of carpet in public areas, painting, and refurbishment of bathrooms. Disposable curtains are monitored and changed on the due date, or if contaminated. Additional environmental cleaning is consistent with HICMR policies.

Rating	Applicable HSF IDs
Met	All

ACTION 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Comments
HICMR and local authorities communicate regarding the risks of infections in the community. The medical record and transfer documentation communicates details of the patients' infectious status. Information is provided to the family via staff education, posters and written information re specific infections.

Rating	Applicable HSF IDs
Met	All

ACTION 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Comments
The hand hygiene program is consistent with the national initiative. Alcohol-based handrubs are widely distributed in clinical and non-clinical areas, and all staff are educated in the correct use of hand hygiene products via online learning. Contractors such as radiology and pathology are assessed via the hand hygiene audit program. The compliance rate of 90% is above the Healthscope benchmark of 87%, and this was recognised by a Healthscope national award. Promotional activities are consistent with the WHO Hand hygiene Day.

Rating	Applicable HSF IDs
Met	All

ACTION 3.11
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Comments
HICMR policies cover aseptic technique, with a risk matrix for assessing aseptic technique and invasive devices, including intravenous access, regional anaesthesia, indwelling catheters, care of PICC lines and dressings. Audits of compliance are conducted in the ward areas and operating theatres, while there are processes to ensure that the pathology staff are appropriately trained and audited in aseptic technique.

Rating	Applicable HSF IDs
Met	All

ACTION 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare
Comments
Healthscope has a group procurement strategy to assess and purchase invasive devices in conjunction with IPC staff, and there are processes in place for education prior to introduction of new products by company representatives. There are various policies and learning packages (e.g. PICCS and Ports, CVC, and wound drains). Patient education is provided on the administration of insulin, Clexane administration and self-catheterisation as required. Audits are conducted of anaesthetic technique for administration of medication

Rating	Applicable HSF IDs
Met	All

ACTION 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
Comments
Staff in environmental services receive annual training and NPH conducts regular auditing of cleaning. Housekeepers are kept abreast of correct procedures for PPE and transmission-based precautions. The provider of the TGA approved chemicals (Ecolab) provides additional training to staff. The HICMR risk assessment report includes environmental services, with the 2024 report showing 81.7% compliance. This led to a review and improvement of chemical products storage in conjunction with Ecolab. The outcome is improved satisfaction for environmental services staff and IPC management. All chemicals are TGA approved and have appropriate hazard and safety information. Cleaning checklists are used for signing off. Outcomes of audits are documented in eQuaMS and reported at the IPC meetings. Position descriptions, duty lists, standard operating procedures, cleaning schedules and quick reference guides placed on cleaning trolleys, and colour coded cleaning processes, underpin effective cleaning practices. Pandemic plans include cleaning for novel infections based on state and national guidelines.

Rating	Applicable HSF IDs
Met	All

ACTION 3.14
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Comments
New equipment and devices are managed by the Healthscope group procurement team, including trials of new products and implementation and evaluation The HICMR risk assessment measures maintenance compliance with all relevant national standards. Processes include the preventative maintenance schedule, cooling tower risk management, waste management plan, waste audit, sharps audit, legionella control and testing, and HEPA filter assessment. The linen service is contracted and monitored by Healthscope Corporate. HICMR policies are in place for waste and linen management. HICMR conducts clinical waste and linen risk assessment audits that include storage and handling of linen. There is a HICMR construction and renovation toolkit available to staff. The facility maintenance program is reviewed annually. The HICMR environmental audit focuses on 'wear and tear.' Results for legionella, cooling towers and HEPA filters are monitored and were reported as compliant. NPH has a contingency plan to respond to novel infections and pandemics, in collaboration with local governing bodies and Nepean Hospital.

Rating	Applicable HSF IDs
Met	All

ACTION 3.15
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Comments
Processes, in line with HICMR policies, are in place for risk assessment and vaccination of staff as per the Australian Immunisation Handbook. There is a robust pre-employment screening program that requires compliance with vaccinations prior to employment and placement on the payroll. Contracts with universities and agencies require compliance with immunisation prior to clinical placement. The IPC coordinator holds responsibility for the program and is supported with two endorsed nurse immunisers. Consent forms and information sheets are available to staff and contractors, and compliance by medical staff is monitored by the Executive. A review of compliance with vaccination for permanent staff indicates high rates of compliance. Parenteral and non-parenteral exposures by staff are reported as being slightly above .05, and .006 respectively for 2023. HICMR holds responsibility to manage staff exposures and is available 24 hours.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Comments
NPH is aligned with NSW Public Health policy for workforce screening and exclusion periods. There is a good uptake of the influenza vaccination and reporting shows staff compliance with immunisation is consistently high. Covid 19 clinics are available at Nepean Hospital. Hospital policies are in place to ensure that staff do not present to work unwell. Visitors are limited to two at a time with further restrictions during a pandemic. Blood and body fluid exposure incidents are followed up by the 24hr HICMR on-call service. Support for staff is provided by the IPC coordinator, WHS, HICMR, Hospital Executive, and access to EAP. A recent improvement is introduction of the electronic data base to monitor staff vaccinations. There is a policy and HICMR contact tracing toolkit available for outbreak management and to record potential exposure to communicable disease. The Outbreak Management Plan is managed by Healthscope Corporate and HICMR. Information and fact sheets are available to contractors regarding the risks of transmissible disease. Contingency plans are in place for ongoing service provision during outbreaks and pandemics in collaboration with other local healthcare facilities and regulatory advice.

Rating	Applicable HSF IDs
Met	All

ACTION 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
Comments
Policies, training via e-Learning, tool kits, skills assessment, and audit are consistent with relevant national and international standards. There is a suite of HICMR modules for cleaning, reprocessing, and sterilising of reusable devices, including endoscopy and ultrasound equipment and HICMR policies and tool kits are implemented for sterilising services, endoscopy and ultrasound probes. Disaster planning for equipment failure occurs in collaboration with Nepean Hospital. The traceability process for critical and semi-critical equipment, instruments and devices is regularly audited for compliance, with work in progress to expand the electronic traceability program across the hospital. A Gap analysis for AS 5369 is work in progress in consultation with HICMR. Processes are in place to safely manage novel and emerging infections.

Rating	Applicable HSF IDs
Met	All

ACTION 3.18
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
Comments
AMS managed by Drug and Therapeutic Committee, is consistent with the Antimicrobial Stewardship Clinical Care Standard. The IPC Coordinator is a member of the committee and provides a report to IPC committee. There is a formulary and traffic light system for antimicrobial management, consistent with current evidence- based Australian Therapeutic Guidelines. ACHS clinical indicators report better that average compliance for timing, correct dose, discontinuation, and timing of management of SAP. It was noted that there were no VRE infections reported. NPH is a member of the Healthscope National AMS Committee. Infection surveillance data includes antimicrobial sensitivities and resistance, and sepsis pathways are in place for adult, paediatric, maternity and neonate, and regularly audited. CMO education is via NPS online modules. Compliance is monitored by the Executive. Pharmacists have input into prescription of restricted antimicrobials.

Rating	Applicable HSF IDs
Met	All

ACTION 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Comments
There are biannual surgical prophylaxis audits for orthopaedic procedures and LSCS. The data reported is close to 100% compliant for all criteria. Results are reported of infection surveillance include antimicrobial sensitivities / resistance. CMO education is required via the NPH online modules. NPH celebrated World Sepsis Day, with a range of promotional material. High risk antimicrobial use is reviewed by pharmacy, and the stock of antimicrobials is limited on Imprest. Annual antibiograms are issued from pathology.

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
Medication management governance is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles. Medication management is overseen by the Medication Safety and AMS working group who report to the Quality Committee, the Medical Advisory Committee and NPH Executive and the National Organisation. Tall Man lettering is used for labelling high-risk drugs as is clear separation. NPH has an effective system for reporting medication incidents and near misses through RiskMan, with the MARS audit system enabling a more in-depth look at any trends. Appropriately experienced and trained staff investigate reported medication incidents, and current incident data is reported to the Medical Advisory Committee and used as a basis for improvement activities and education.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Comments
NPH monitors the medication management system's effectiveness through incident reporting and audits. Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified. Medication incidents are low with no serious incidents noted. The introduction of electronic referrals (WebPAS) to the Clinical Pharmacist has ensured prompt referral and appropriate targeting of patients requiring pharmacy intervention. Medical Officers document all medications in the patients' medical record, however while VTE risk is assessed on admission and documented in the clinical notes, few VMOs are indicating in the space provided on the medication chart that they have reviewed the VTE assessment prior to prescribing anticoagulants.
Suggestion(s) for Improvement
Identify strategies to ensure VMOs review VTE risk when prescribing anticoagulants and document on the medication chart that they have done this.

Rating	Applicable HSF IDs
Met	All

ACTION 4.03
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
The organisation involves patients in their care by providing appropriate information on medications and treatments and fostering shared decision-making. Staff ensure that there is a clear understanding of the effects of prescribed medications and their correct use in conjunction with the Clinical Pharmacists during admission and prior to patient discharge. Patients indicated that medication management was discussed with them and that they felt involved in the process and were able to understand the information provided.

Rating	Applicable HSF IDs
Met	All

ACTION 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Comments
Scope of practice for medication management is defined in policy and in position descriptions for clinicians. NPH has sound processes to ensure that clinicians operate within their medication scope of clinical practice. Any incidents or near misses reported in prescribing, dispensing or administering medications are subject to review, further reporting and the identification of improvement strategies or further education individually or group should this be necessary.

Rating	Applicable HSF IDs
Met	All

ACTION 4.05
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
Comments
A best practice medication history (BPMH) is undertaken as soon as practicable with patient pre-admission input which may include assistance from family or carers and documented in the clinical record. Information on allergies and adverse drug reactions is clearly recorded in the clinical file and included in any patient transfer. This documentation is done well and all legislative requirements for prescribing, dispensing and administration covered. Compliance with completing the BPMH is 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Comments
Clinicians confirmed that current medications are reviewed for accuracy and consistent with the BPMH on presentation and at handover points, forming part of the treatment and care plan. Newly prescribed medications are explained to the patient and family by the Clinical Pharmacist and staff. Antimicrobial compliance is high, at over 95%, with orthopaedic prophylaxis antibiotics ceased within 24 hours identified as 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation
Comments
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored, and records confirmed their consistent use. Compliance with documenting medication related alerts is 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Comments
Adverse drug reactions are reported through the incident management system and the organisation has a strong culture of reporting incidents and near misses in the clinical record and on RiskMan. Medication-related incidents are reviewed by the Quality Committee and Medication Advisory Committee.

Rating	Applicable HSF IDs
Met	All

ACTION 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Comments
The organisation has an established policy and process for reporting adverse drug reactions to the TGA where required, and staff were able to describe this. To date there have been no notifications over the past 12 months

Rating	Applicable HSF IDs
Met	All

ACTION 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Comments
Determining the need for a medication review is based on risk and clinical need. Responsible clinicians were able to describe the process, it is documentation and how action taken in response to the review is followed though. To manage a patient's medication, the accuracy of the medication chart and any verbal handover or discharge medication information is supported by clear and accurate charting and documentation. Clinical documentation supported this.

Rating	Applicable HSF IDs
Met	All

ACTION 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Comments
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Patients reported that they understood the medication information that was provided to them. NPH has access to excellent clinical pharmacy support through a contracted in-hospital clinical pharmacist. Online and hard copy Therapeutic Guidelines, printable patient information, pharmaceutical company literature approved for use by NPH are all available. Patients' current medications are brought with them for the episode of care and taken home on discharge or placed in a pharmacy collection bin for return and destruction by the contracted pharmacy.

Rating	Applicable HSF IDs
Met	All

ACTION 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes
Comments
Staff confirmed that a list of current medications can be produced whenever a patient is discharged or transferred, and this was supported by discharging patients. A medication list is provided to patients and their referring GP on discharge. Performance is audited and compliance is 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Comments
Clinicians have access to information and medication management support tools electronically, in hard copy and through contracted pharmacy services. Clinicians reported their knowledge of these tools and the ability to readily access this information.

Rating	Applicable HSF IDs
Met	All

ACTION 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
Comments
The organisation monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage of medications, including cold chain management, distribution and disposal. Incidents are reported through the incident management system and the governance structure to the appropriate committees.

Rating	Applicable HSF IDs
Met	All

ACTION 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
Comments
Staff reported that high-risk medications are clearly identified, with an appropriate management system in place for the storage, dispensing and administration of those medications. Any issues are reported to and addressed by the Medication Advisory Committee, and any investigations required are undertaken by approved and appropriately trained staff. There were no reported incidents related to high-risk medications over the previous 12 months.

Rating	Applicable HSF IDs
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Comments
The Comprehensive Care Plan Policy outlines the requirements for developing a comprehensive care plan. Risks associated with Comprehensive Care are included in the organisations risk register and are regularly monitored. Screening identifies patients at risk of harm, and mitigation strategies are implemented to reduce identified risks and are documented in the comprehensive care plan. Training requirements have been identified and included in the training matrix. Safety huddles provide opportunities for staff to discuss issues related to comprehensive care

Rating	Applicable HSF IDs
Met	All

ACTION 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Comments
An audit program is in place to monitor NPH's performance in providing comprehensive care to patients in line with the Policy. The quality Action Plan aims to improve compliance with comprehensive care requirements and demonstrates that the organisation has effective processes to identify areas for improvement through the safety and quality processes in place which include incidents, complaints, patient feedback and audit results.

Rating	Applicable HSF IDs
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Clinicians actively involve patients in their own care, with goals of care developed in partnership with patients and documented on the care board in the patient's room as well as in the comprehensive care plan. Clinicians were observed reviewing care goals with patients and including patients in the handover process. Clinicians described how shared decision-making is important in developing care plans, giving an example of a birth plan to describe this process.

Rating	Applicable HSF IDs
Met	All

ACTION 5.04
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care
Comments
Clinicians document and maintain the comprehensive care plan in the health care record and communication processes including huddles, clinical handover and multidisciplinary care meetings are in place to share information to assist in care and discharge planning. Patients are managed in the appropriate clinical setting, such as maternity, paediatrics, orthopaedics, high dependence unit, etc. Wards may have outlier patients, but they are moved as soon as possible to the appropriate clinical setting. Referral processes are in place for Allied Health. Patients may be transferred to Nepean Hospital if a higher level of care is required. The medical consultant has overall accountability for the patient.

Rating	Applicable HSF IDs
Met	All

ACTION 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Comments
Multidisciplinary care is established, and the role of team members is defined and understood across the organisation, with staff describing referral processes to support multidisciplinary collaboration and team meetings to support teamwork.

Rating	Applicable HSF IDs
Met	All

ACTION 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Comments
Comprehensive care planning is done through multidisciplinary teamwork. Referrals to allied health staff are made to Allied Health services contracted from Nepean Hospital. Referral processes are also in place for other specialist medical services. Multidisciplinary meetings support collaboration and clinicians described how they work together in developing and delivering comprehensive care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
Comments
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was sighted in clinical documentation. Risk assessments are undertaken on admission, at seven days and following any change in patient condition. A comprehensive care plan in line with the patients identified goals is developed from the risk assessments and changed as necessary. Discharge planning commences on admission in consultation with the patient and family. A patient journey was undertaken during assessment which showed that processes are in place and well embedded ensuring competent comprehensive safe care throughout the patient journey. 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.
Suggestion(s) for Improvement
With review of the comprehensive assessment documentation underway, consider a scaled back version for reviews with the ability for clinicians to record change and need without completing/duplicating a full assessment as discussed at assessment

Rating	Applicable HSF IDs
Met	All

ACTION 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Comments
The organisation has processes for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. This is audited with high compliance however patient numbers are low. Staff described the processes for this. Links are also available to the Aboriginal Liaison staff at Nepean Hospital and the local Aboriginal Association, which has active women's and child and family groups.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09
Patients are supported to document clear advance care plans
Comments
Policies are available at NPH regarding Advance Care Planning. Patients are asked at pre-admission if they have an Advance Care Plan (ACP) and to bring a copy with them on admission. ACP are placed in the patients' clinical notes on admission and included in any handover or transfer of care. Support is available should patients identify they wish to undertake an advanced care planning process.

Rating	Applicable HSF IDs
Met	All

ACTION 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Comments
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the organisation's governance structure. A review of clinical documentation reinforced this, including the inclusion of "What matters to me" alongside patient goals both in the clinical record and on the bedside care board. The organisation is compliant with the requirements of Advisory AS18/14.

Rating	Applicable HSF IDs
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Screening is undertaken on admission, at seven days and if there is any change in a patient's condition (e.g. returning to ward from theatre). Documentation audits demonstrate a high level of compliance with initial screening, assessment and care planning processes, with confirmation of these results observed in the clinical records. The comprehensive screening tool is currently being reviewed following a drop in compliance of completing reviews and feedback from staff on applicability. A suggestion has been made about this in Action 5.07.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment and appropriate action plans developed to mitigate them and clinical referrals are documented in the care plan, identified on the patient bedside board (if appropriate), discussed at bedside handover, and documented in referrals for identified care needs. An alert sheet is at the front of the clinical notes to record any alerts and allergies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Comments
Clinicians and patients described the role patients and families play in their care and in determining patient-centred goals that meet their specific needs. Clinical documentation reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. Interactions between staff, patients and families that demonstrated this partnership in care and decision making were observed. Care plans reflect contemporary evidence-based best practice principles. The requirements of Advisory AS18/15 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
Comments
Patients and families articulated their level of engagement in their care and expressed satisfaction that they actively participated in decision making as much as they wanted at all points of care and transition. Goals of care are monitored, and care planning modified in response to change in goals, changing clinical status needs or risk profile.

Rating	Applicable HSF IDs
Met	All

ACTION 5.15
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Comments
Processes are in place for patients at end of life and staff interviewed were aware of them. The organisation has aligned is processes to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. The Last Days of Life resource folder was introduced in 2020, just before their last assessment and the End-of-Life Pathway provides guidance and resources for staff. Processes for escalation of care by staff, patients and families are in place. The Maternity unit has excellent processes in place to manage both the parents and families following stillbirth or loss of a baby.

Rating	Applicable HSF IDs
Met	All

ACTION 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Comments
The organisation has 24hr access to specialist palliative care services and advice through Nepean Hospital. hrs. Palliative Care specialists and teams have visiting rights to NPH ensuring best practice care is available. Staff were aware of the scope of these services and how to access them.

Rating	Applicable HSF IDs
Met	All

ACTION 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Comments
A review of clinical documentation confirmed that ACPs are recorded in the patient's healthcare record. Clinicians in could describe the process in place to ensure that patients with an ACP are identified, their inclusion in clinical documentation and processes to ensure all staff are aware of them and that care is provided in accordance with these plans. Processes are in place to assist and support patients and families wishing to complete an ACP.

Rating	Applicable HSF IDs
Met	All

ACTION 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Comments
Supervision and support for staff providing end-of-life care are available through a specialist palliative care team with individual and group debriefing and access to external support services (EAP) if needed. Staff know how to access support services and acknowledged feeling supported in this area of care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Comments
Goals of care for patients at end of life are developed in partnership with patients, carers and families and documented in the clinical record. The planned goals are reviewed regularly, and changes are documented. Audits of all end-of-life patient files review the care given and its alignment with patient and family planned goals are undertaken. Reports are tabled at appropriate meetings and discussed with clinical staff at ward meetings

Rating	Applicable HSF IDs
Met	All

ACTION 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Comments
The organisation supports shared decision-making about end-of-life care with patients and families. This is supported by regular communication and documented in the clinical record. Support for decision-making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care and uses the NSW Clinical Excellence Last Days of Life Toolkit. This provides support to clinicians in the provision of care and to patients and families during this period of care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Comments
The Corporate Policy and Procedure Healthscope Policy – 'Pressure Injury – Prevention, Identification and Management of' provides the framework for clinical risk assessment for pressure injuries using the Waterlow tool. Regular audits measure compliance with best practice as per policy. The June 2024 HAC reports zero pressure injuries. All wounds are assessed on the Wound Care Assessment and Plan medical record. Assessment of pressure injuries includes reference to other clinical risks such as nutritional assessment.

Rating	Applicable HSF IDs
Met	All

ACTION 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
Comments
Clinical risk assessment and care pathways are used to monitor patients at the risk of developing pressure injuries shift by shift and when the condition of the patient changes.

Rating	Applicable HSF IDs
Met	All

ACTION 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Comments
Patients and carers are informed about the risk of pressure injuries by clinicians, and there is written information in the patient admission information and flyers available in the clinical departments. Processes are in place to hire pressure relieving mattresses for beds and patient chairs. There are a range of other products available to clinicians to mitigate the risk of pressure injuries. Use of pressure relieving devices is documented in the clinical medical records, and perioperative charts. No pressure injuries were reported as at June 2024.

Rating	Applicable HSF IDs
Met	All

ACTION 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Comments
Healthscope corporate policies underpin clinical risk assessment for falls prevention, and patients at risk are allocated beds to facilitate closer observation. Post-fall management includes medical review, referral to physiotherapy and pharmacology review. Patient information flyers 'Keeping a step ahead of falls' are provided to patients on and during admission. June data shows no falls with intracranial injury. Actual falls year to date are lower than the benchmark of 0.24%. The Patient Information Directory has information about falls prevention including maternity services to keep the baby safe from falling.

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
Comments
A recent quality improvement activity involves the purchase of sensor mats, which was a collaborative initiative between the geriatrician and nursing staff and is well received.

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Comments
Advice from clinicians is supported by written information about falls prevention strategies which is available to carers and families via the patient admission booklet and flyers available in the clinical units

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Comments
All patients are assessed on admission using the Malnutrition Screening Tool included in the Clinical Risk Assessment. NPH has processes for referral to the contracted dietitian who liaises closely with the catering staff. Special diets are noted on WebPAS.

Rating	Applicable HSF IDs
Met	All

ACTION 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Comments
Clinical risk screening includes nutritional assessment, and all patients are allocated a diet code in WebPAS on admission. Patients are weighed and assessed using the MST and management Guide, within 24 hours of admission and thereafter weekly. There are specific referral criteria to a dietitian as well as referral processes to an occupational therapist for special feeding equipment, and patients with swallowing difficulties are referred to a speech pathologist. Ward staffing must be sufficient to assist with feeding if required. The quality improvement project regarding diets for cardiac patients, initiated by nurses and approved by the cardiology craft group meeting to implement low salt diets is impressive. Bariatric patients are routinely referred to a dietitian. Perioperative diabetes management policies are in place.

Quality activities include Sip Til Send project to improve hydration of patients undergoing a procedure, availability of special diets after hours, speech therapy education for dysphagia and the food allergen matrix in the kitchen. |

Rating	Applicable HSF IDs
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
There is a Healthscope Corporate Policy – Delirium and Cognitive Impairment Prevention and Management. NPH has a working party for delirium management, well supported by a geriatrician with a special interest in perioperative care to assess and manage delirium. A significant quality improvement activity is the referral of at-risk patients from the VMO to a geriatrician who assesses the patient prior to admission and writes a care plan. Follow up care from the geriatrician occurs during the admission. There is also a good referral process to the geriatrician for patients whose cognitive state changes during the admission. There is a patient and carer information flyer on cognitive impairment that includes reference to delirium and dementia. Strategies for management of delirium are listed on the flyer, as are helpful contacts i.e. Alzheimer's Australia and the Australasian Delirium Association. The intent of AS22/01 is met.

Rating	Applicable HSF IDs
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
The Carer TOP5 (Clinical Excellence Commission) aims to personalise care for patients with cognitive deterioration by identifying the best way to communicate with patients at risk. This is available in a flyer readily accessible to patients / carers and families.

Rating	Applicable HSF IDs
Met	All

ACTION 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Comments
Screening on admission and during care identifies patients at risk of self-harm. Risks are reported immediately to the CMO, treating VMO and hospital Executive. Patients are specialled until they are transferred to an appropriate facility for care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.32
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Comments
Follow-up care becomes the responsibility of the care facility that the patient is referred to, and the VMO.

Rating	Applicable HSF IDs
Met	All

ACTION 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Comments
Staff are trained in risk assessment and the management of aggression. There are emergency call charts placed near the phones to guide prompt and appropriate action. Policies are in place for Child Protection.

Rating	Applicable HSF IDs
Met	All

ACTION 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
Comments
Except for one incident when the police were required to intervene, all behavioural incidents (11) over the past 12 months were rated as low risk. It was noted that there were no restrictive practices required to de-escalate the situation. WHS conducted a training needs analysis for occupational violence and aggression. The risk of violence is mitigated via pre-admission assessment of the patient, patient code of conduct, dissemination of workplace aggression and violence information, eLearning and workshops, audits of occupational violence and aggression, and security audits.

Rating	Applicable HSF IDs
Met	All

ACTION 5.35
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body
Comments
Physical restraint is not permitted, and low dose chemical restraint is only used after risk assessment and consultation with the VMO / geriatrician. The use of chemical restraint is always negotiated in collaboration with the family and carer. No restraints were recorded in 2023.

Rating	Applicable HSF IDs
Met	All

ACTION 5.36		
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body		
Comments		
This action has been assessed as not applicable with reasons for the decision noted below.		
Rating	**Applicable HSF IDs**	
NA	All	**NA Comment:** Seclusion is not used at Nepean Private Hospital. Patients identified at risk of mental health issues are promptly assessed by the VMO and specialled until transferred to an appropriate facility. The policy for exclusion of admission states clearly that patients that require psychiatric care will not be admitted. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

Standard 6 - Communicating for Safety

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

ACTION 6.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Comments
NPH has policies to support effective clinical communication, including Acceptable Abbreviations, Specimen Collecting and Handling, Identification of the patient and intraoperative requirements, Admission of the patient to recovery, Blood collection for newborn screening test, and Neonatal transfer. Observational audits of handover measure compliance with policies and identify training requirements. The Healthscope Corporate policy, Clinical Handover – Departmental and Intra-unit includes correct identification and procedure matching. Handover is documented in the clinical record.

Rating	Applicable HSF IDs
Met	All

ACTION 6.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Comments
Communication for safety incidents are audited, and reports and improvement strategies are tabled n departmental minutes, the Patient Safety and Quality Meeting, craft groups and the MAC.

Rating	Applicable HSF IDs
Met	All

ACTION 6.03
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Comments
Patients are informed of clinical bedside handover via discussion and a flyer that encourages their participation. Patient experience data is collated and benchmarked with the previous period. In general terms there has been a steady improvement in feedback regarding nurse handover at the bedside, access to the nurse caring for the patient, quality of treatment and care received, shared decision-making, documentation, and patient engagement regarding goals of care. If compliance is less than 89%, action plans are developed at the clinical unit and monitored for improved compliance. Data is broken down by clinical unit and communicated with staff. Furthermore, the net promoter score shows improvement from the previous year.

Rating	Applicable HSF IDs
Met	All

ACTION 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes

Comments
The CMOs and MAC confirmed a good escalation process and communication about patient care and emerging risks. The nursing staff reported good relationships and collaboration with the medical staff and are comfortable communicating with the VMOs regarding patient care. The CMO job description requires handover at the commencement of each shift, while the VMO job description requires them to be notified of any significant change in the patient's condition.

Rating	Applicable HSF IDs
Met	All

ACTION 6.05
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
Comments
Compliance was noted with the use of three approved identifiers at admission, in the wards and operating theatres and procedural areas, and at the transfer of care, as per the policy directive.

Rating	Applicable HSF IDs
Met	All

ACTION 6.06
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care
Comments
Processes are in place for correct identification and procedure matching as per the Correct patient, Correct Procedure and Correct Site Policy. This was observed in practice in the perioperative areas and at administration of medication in the ward.

Rating	Applicable HSF IDs
Met	All

ACTION 6.07
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover
Comments
Information is communicated using ISOBAR. The clinical handover audit on the wards is extensive, and mostly reports high levels of compliance. A 2024 audit indicated a significant improvement in handover of discharge information. It is expected that the template on the new patient boards will be helpful to increase focus on goals of care.

Rating	Applicable HSF IDs
Met	All

ACTION 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
Clinical handover is aligned with ISOBAR. Handover by medical and nursing staff in a variety of clinical settings confirmed patient and carer involvement in handover that included patients' goals and preferences and the safe transfer of care. Regular huddles in the clinical areas ensure good communication regarding issues of the day. The multidisciplinary huddles at the commencement of each surgery session ensure safe care for the perioperative patient. A recent audit of clinical handover involving the patient carer showed 100% compliance.

Rating	Applicable HSF IDs
Met	All

ACTION 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Comments
Medical and nursing staff confirmed good communication and liaison regarding changes in patients' condition and critical information. Patients are encouraged to be involved in their care, and their wishes are documented in the medical record and on the patient care boards.

Rating	Applicable HSF IDs
Met	All

ACTION 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Comments
Patients are encouraged to speak up using the REACH process at any time. Regular rounding and handover actively engage patient and carer feedback regarding concerns.

Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan
Comments
Patient care boards are updated to include goals of care, risks, changes to treatment plans, patient preferences, and identification of staff at the change of shift. Changes are documented in care pathways and risk assessment documentation. There is a clear understanding that the VMO is always responsible and accountable for the patient during the continuum of care.

Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
NPH has policies to guide blood management practices which reflect best practice. Risks associated with blood management are identified through the safety and quality systems, and audits are regularly conducted on blood management practices with results monitored through the governance structure. Staff complete training through BloodSafe in line with the training matrix.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	
As noted above, the performance of the blood management system is monitored through incident reporting and the conduct of regular audits. Clinicians described retrospective audits on patients who have received blood to check that the correct processes were followed and documentation completed, including consent and the blood order form. Other audits are completed and if the results fall below the set target, an action plan is put in place and the process is re-audited to check for an improvement in the result. This information is reported to the Safety and Quality meeting, the Medical Advisory Committee and to Craft groups for review. Adverse events are managed in accordance with incident management processes though staff reported that there had been no incidents reported.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Patients are involved in decision-making around blood transfusion whenever possible, with Information on the risks and benefits of blood transfusion provided to the patient prior to consent being obtained. Clinicians describe how shared decision-making is important when obtaining consent from Jehovah's Witnesses, to determine what they can or cannot accept, with staff noting that these patients may accept small blood components like albumin but will not accept whole blood components. These patients carry cards with this information on it.

Rating	Applicable HSF IDs
Met	All

ACTION 7.04
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Comments
NPH has patient blood management practices in place that optimise blood red cell mass and iron stores to reduce the need for blood transfusion, with clinicians explaining that this is done during pregnancy with regular blood tests to determine haemoglobin and ferritin levels and treating low levels with Ferinject infusions. Patients are assessed at preadmission for risk of bleeding and action is taken to reduce the risk. A recent change to single unit blood transfusion has been introduced, with ongoing monitoring of the newly established process.

Rating	Applicable HSF IDs
Met	All

ACTION 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Comments
Patient consent includes information on the blood or blood product to be transfused and patients cannot proceed with surgery if consent has not been completed, with consent checked as part of the time-out procedure.. Audits of consent for blood transfusion are conducted, Documentation in the healthcare record includes transfusion history, transfusion details, pathology results, request forms, blood transfusion documentation and observation charts. .

Rating	Applicable HSF IDs
Met	All

ACTION 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Comments
Policies support clinical practice and guide clinicians in decision-making. Clinicians have access to learning resources including those from BloodSafe eLearning Australia, which they are required to complete. There are specific resources focused on maternity patients. The audit program monitors all aspects of blood transfusion.

Rating	Applicable HSF IDs
Met	All

ACTION 7.07
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria
Comments
Any transfusion related adverse event is reported and documented in RiskMan and the patient 's healthcare record. This is managed in accordance with the requirements of the incident management process and reported to the Patient Safety and Quality meeting, the Medical Advisory Committee and the craft group and reported to NSW Health if it is a serious adverse event. Used blood bags are returned to the Blood Bank.

Rating	Applicable HSF IDs
Met	All

ACTION 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Comments
NPH participates in haemovigilance activities with clinicians describing the activities undertaken and how they are reported through the governance structure, and to State and National bodies in line with the national framework.

Rating	Applicable HSF IDs
Met	All

ACTION 7.09
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Comments
The Blood Fridge Management and Unused Blood Products policy guides processes for the receipt, storage, collection and transport of blood and blood products. A blood register located by the blood and blood product fridge, records the receipt, storage and issue of blood and blood products, and the register is audited. The blood and blood product fridge, located in the Operating Theatre, is locked and the temperature is monitored on a daily basis. Blood storage audits are undertaken.

Rating	Applicable HSF IDs
Met	All

ACTION 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Comments
NPH has processes for managing the availability of blood and blood products to meet clinical needs and to eliminate avoidable wastage. To better manage blood usage, NPH has made a change from a two-unit blood transfusion to a single unit blood transfusion, with processes in place to order further blood if required. Patients or family members can donate their own blood prior to surgery. Emergency O negative blood is held at NPH.

Rating	Applicable HSF IDs
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Comments
NPH has policies and procedures for recognising and responding to acute deterioration and staff were able to describe their role in such events. The Deteriorating Patient Working Group provides oversight of clinical deterioration and reports to the Quality Committee. Staff could articulate the intent of the policy and procedure and provide examples of how this is undertaken in practice. Observation charts are used to flag a clinical review, and the Medical Emergency Team (MET) response enables clinicians to recognise and escalate clinical deterioration. There is also the capacity to identify mental health deterioration with the use of appropriate assessment tools.

Rating	Applicable HSF IDs
Met	All

ACTION 8.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Comments
Systems are in place for monitoring the identification and management of acute deterioration and this is reported through the Quality and Medical Advisory Committees and the NPH Executive and to clinicians for the purposes of clinical review. Incidents and trends are recorded and reviewed through RiskMan. Training and support for clinicians is prioritised and escalating care is included in orientation and clinical settings. Staff are encouraged to discuss any identification of deterioration however small with senior staff or call a MET if concerned.

Rating	Applicable HSF IDs
Met	All

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
There is a process to support partnering with consumers in recognising and responding to acute deterioration which involves meeting their information needs and making decisions collaboratively, and this was confirmed by Staff and patients. Examples of the shared decision-making were observed and supported by clinicians and patients. Medical staff undertaking rounds described how they involved patients and families in both medication and clinical reviews. Rounding by NUMs and the Leadership Team provide opportunity for patients and families to discuss their concerns.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital signs are monitored using the national observation chart with clear track and trigger directions. Regular audits of clinical documentation supported this. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation or intervention. The introduction of Clinical Review stickers within the patients' notes shows changes to be reported in safety huddles prior to handover and during bedside handover. Staff described how this system works and how they would escalate concerns ranging from patient feedback, discussions with peers and managers, how to request a clinical review and call a Medical Emergency Team response	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
Policies and procedures support staff in identifying acute deterioration in mental state including the risk of delirium. Assessment and care planning documentation showed that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration or delirium. Top 5 training supports staff to recognise delirium and dementia. Clinical documentation is audited regularly and compliance with cognition screening is reported as 100%. Processes are also in place to support timely communication between members of the treating team and the patient and family members. The requirements if Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The organisation monitors the identification and management of acute physiological, mental status, pain or distress as well as concerns raised by staff, patients and families through clinical documentation audits, incident management and clinical review. The observation chart has clear parameters built into the chart linked to steps to consider referral for physical and mental state clinical review in a timely manner. Staff and patients were aware of these processes and able to describe them, including the process for escalating care. Clinical pathways identify moments in time to monitor patients, such as the sepsis pathway, or the levels of care for patients who show signs of decline in either physical or mental health in accordance with risk assessments for dementia and delirium. Documentation identified policies and procedures to support clinical staff in the management and escalation of clinical deterioration which are current and reference best-practice. The requirements if Advisory AS 19/01 have been met (8.6 b, c, d, e).

Rating	Applicable HSF IDs
Met	All

ACTION 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Comments
Processes are in place for patients or families to directly escalate care, and clinical staff, patients and families confirmed the escalation system used across the organisation supported this. Posters are displayed within the facility and included on the newer patient bedside boards. There has not been any reported use of this system in the past 12 months, with clinical assessments and staff rounding appearing to reduce the need for this process.

Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Comments
The policy for escalating care is clear and provides direction for staff to respond to a clinical emergency. Staff described this process and reported that they are encouraged by clinical leaders to use the process if they have concerns. Documentation supporting the evaluation of these processes is reported through the Quality and Medical Advisory Committees. Responses to MET calls are led by HDU staff, the CMO, and with support from all clinical areas. There is formal review of the processes leading to the MET call, the actions taken, any learning to improve the response and interventions of the MET response.

Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09
The workforce uses the recognition and response systems to escalate care
Comments
Staff described the systems for escalating care consistent with the organisational policy, and the circumstances during and following an escalation of care for both the patient and staff involved. Reports are provided to the Quality and Medical Advisory Committees and are used to identify areas for improvement.

Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Comments
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate and to initiate an effective MET call. Emergency call buttons are strategically placed and identify the location of the call. Compliance with training is reported as high. Basic Life Support training is conducted and monitored at ward level with managers aware of who required updated sessions using strategies to support staff to attend to this training. All areas have 24hr access to senior staff with ALS skills.

Rating	Applicable HSF IDs
Met	All

ACTION 8.11
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support
Comments
The organisation provides 24hr access to clinicians with ALS skills and competency on all shifts, including a CMO onsite. Audit data showed a compliance rate for ALS training at 100%. If transfer to another appropriate health service is required, MET is used and the organisations internal referral processes followed.

Rating	Applicable HSF IDs
Met	All

ACTION 8.12
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
Comments
NPH is not a gazetted Mental Health facility and interviews with clinicians confirmed the process for referral to mental health services to ensure the needs of patients whose mental state has acutely deteriorated are met. The Edinburgh Post Natal Screening Tool is used in Maternity. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Comments
Policies and procedures are in place for the timely assessment and referral to definitive care for patients who physically deteriorate. Escalation involves transfer to the High Dependence Unit or to Nepean Hospital with ready access for transfer across a connecting bridge. Staff of the emergency response team take part in this transfer between the hospitals, as do Ambulance Paramedics. Staff were able to explain these processes and the effectiveness of escalation of care processes is monitored through the MAC.

Rating	Applicable HSF IDs
Met	All

Org Name   :   Nepean Private Hospital
Org Code   :   120314

Recommendations from Previous Assessment

NIL.