National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Final Report

Ringwood Private Hospital

RINGWOOD EAST, VIC

Organisation Code: 220194
Health Service Facility ID: 101103
ABN: 86042707542
Assessment Date: 18 – 19 October 2023

Accreditation Cycle: 1

Contents

Introduction

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

ACHS is approved to accredit the following standards

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

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

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

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

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

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

The Commission works in four priority areas:

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

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

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

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

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Merrin Prictor	Yes
Assessor	Paula Elliott	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Ringwood Private Hospital . The accreditation decision was made on 20/11/2023 and Ringwood Private Hospital was notified on 20/11/2023.

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Ringwood Private Hospital underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 18/10/2023 to 19/10/2023. The NS2.1 Short Notice Assessment required 2 assessors for a period of 2 days. Ringwood Private Hospital is a Private Health Service. Ringwood Private Hospital was last assessed between 22/10/2019 – 24/10/2019.

PICMoRS was used to conduct this assessment. 75% of available time was spent in operational areas during this assessment.

Ringwood Private Hospital (RPH) is part of the Healthscope group. The service provides inpatient cancer care including surgical, chemotherapy and pre and post cancer services. Palliative care services are also provided.

Governance at RPH is a mix of Healthscope national and local structures which assessors found supported integrated governance frameworks and strategic planning. Quality improvement and risk management is very well managed and there is a strong incident reporting culture. It was evident that care was based on contemporary evidence and variation was monitored and addressed where appropriate.

There is a strong consumer voice at RPH, with consumer consultants seen as part of the care team. Their role to liaise with patients and provide feedback and advocacy is appreciated by staff. There were many examples provided to assessors of person-centred care and support for patients in their decision making. This was especially evident for end-of-life care. A detailed consumer toolkit supports consumers who have been involved in many projects including REACH.

The Infection Prevention and Control system across RPH is effectively supported by the IPC coordinator and the Infection Prevention and Control Committee (IPCC). The system is also supported through the Healthscope contract with HICMR. It is evident that there is effective monitoring of infection prevention, care, and treatment.

RPH is compliant with the requirements of AS/NZS 4187:2014 with contractual arrangements with partnering Healthscope hospitals during renovations. Staff immunisation and occupational exposure are well managed as is antimicrobial stewardship.

Medication is managed with a combination of a contracted clinical pharmacist and RPH run pharmacy services. The onsite compounding service was suspended at the time of assessment pending a review of this service at Healthscope sites.

Risk screening tools are used on admission and throughout the patient journey enabling the effective management of risk, prevention of deterioration and the development of an individualised appropriate care plan, provision of ongoing care, referral to appropriate disciplines and services through to discharge.

Pressure Injury, falls and nutrition risk are an integral part of care planning and are managed well with systems in place to ensure all patients on admission were screened.

Identification processes for delirium and dementia are in place with appropriate processes to identify and manage these patients. Escalation of care need is clearly identified by staff and processes are in place for staff, patient/family, and carer escalation of care. A Patient journey was undertaken during assessment with processes well embedded to ensure competent comprehensive safe care throughout this journey.

There is evidence at RPH of systems in place to ensure timely, effective communication that supports the provision of and documentation of continuing, coordinated best practice safe patient care. The introduction of contemporaneous bedside documentation is a good decision and working well.

Strategies are in place across the organisation to clearly identify patients, communication of information both routine and critical for both patients and staff, ensuring continuity of care. The Safety During your Stay pamphlet replacing the Back to the Bedside one is a good initiative, clear, concise, easy to read yet covering all areas important to the patient and family.

There is a determined intent to enable patients to be involved in communication of their goals of care during bedside handover. Assessors were impressed in the way these were carried out, especially approaching the patient first and enabling their participation rather than the documentation at the end of the bed.

Patient identification time out and procedure matching were all observed and well done. Blood and blood products are administered to patients at RPH as a planned procedure as no emergency services are provided. Assessors were able to speak with patients during these procedures and it was evident that the importance of checking and monitoring was well practiced. The information provided to the patient and the strict indications for whole blood transfusion ensured the procedure was safe and effective.

Policies and procedures in place for the response and recognition to acute deterioration. Training and education are consistent with both clear outcomes and competency measures in place. The recognition and response systems are sound, effective with outcomes reported on in a consistent manner, with data on all MET calls entered on RiskMan, investigated, and reported. Clinicians actively involve patients and families in their own care and have a focus on inclusion and shared decision making at all times ensuring that the patient is able to understand the information being shared. Patient care boards ensure clear communication between all participants on patient care, with REACH procedure posters clearly explaining to patients, carers, and families the process of the escalation of care.

Processes in place allow clinicians to detect acute physical and physiological deterioration by accurate documentation and monitoring with interventions actioned in consultation with the treating team. With processes in place to escalate care and/or initiate an emergency response with Clinicians well trained in BSL with ALS cover 24/7. Equipment and emergency trolleys are standardised and positioned and available to meet the hospital’s needs. Rapid referral is available for both medical and mental health emergencies.

Summary of Results

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

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

Sites for Assessment

Ringwood Private Hospital

Site	HSFID	Address	Visited	Mode
Ringwood Private Hospital	101103	36 Mt Dandenong Rd RINGWOOD EAST VIC 3135	Yes	On Site

Contracted Services

The following contracted services are used by Ringwood Private Hospital

Provider	Description of Services	Verified During Assessment
Selkirk	Pan Flushers and Sanitisers	Yes
BGIS/Nordic lifts	Lifts	Yes
BGIS	Suction Equipment	Yes
BGIS/Power Protect	Generators	Yes
BGIS/Astrovac	Ducted Vaccuming	Yes
BGIS/Power protect	Emergency UPS	Yes
Norfolk - current 2-year agreement	Kitchen equipment	Yes
Adams Pest Control	Pest Control	Yes
BGIS/FES	Fire safety and paging systems	Yes
BGIS - current	Boiling water units	Yes
BGIS/FES	Fire safety and inspections	Yes
Arjo Huntleigh/Service Assist	Patient lifters	Yes
BGIS - current	Electrical maintenance	Yes
BGIS	Floor coverings	Yes
BGIS/FES	Emergency Lighting	Yes
BGIS/HydroChem	Water softener systems	Yes
Chemtronics (B10 Medical)-HSP Contract	Medical Gas instruments and biomedical equipment	Yes
Testel - annual	Electrical Tagging	Yes
HSP contract/Coregas	Medical gases	Yes
Frostline	Refrigeration Medical	Yes
Daniels/Clearaway Healthscope current	Confidential waste	Yes
HICMR Pty Ltd -HSP contract	Infection Control	Yes
Spotless linen- HSP contract	Linen and Laundry	Yes
Dorevitch Pathology; Melbourne Pathology; Anapath, Australian Clinical labs	Pathology Services	Yes
HPS -HSP Contract	Pharmacy services	Yes
Lumus Imaging	Radiology	Yes
Genesis Care Victoria	Radiotherapy services	Yes
Jani king	Theatre Cleaning	Yes

Provider	Description of Services	Verified During Assessment
Healthscope - Clifford Hallam Supplies- HSP contract	General Supplies	Yes
Eat Well Nutrition	Dietitian	Yes
BGIS/Assa Abbloy - current	Automatic Door	Yes
Nationwide - current 2 years	Camera Security	Yes
BGIS - current	Concreting	Yes
Norfolk - current local agreement	Dishwasher Kitchen	Yes
Alliance - Healthscope current	Data Cables/phone lines	Yes
BGIS - current	Drainage	Yes
BGIS/Gencare Services	Diesel Fuel	Yes
BGIS	Engineering	Yes
Service Assist	Food and General trolleys	Yes
Chambers Maintenance Service	Gardens and Grounds	Yes
Daniels/Clear away	Grease Pit pump out	Yes
Frost Line - current 2 years	Ice machines	Yes
Statewide Lock Smith	Locksmith	Yes
Service Assist	Patient Beds and trolleys	Yes
Healthscope IT/Progility	Phones and PABX system	Yes
Frostline	Refridgeration- general	Yes
BGIS	Stainless Steel	Yes
Selkirks	Washing disinfectors steriliser	Yes
Healthscope Contracted Suppliers	Supplies	Yes
Pink Lady- HSP contract	Feminine Hygeine Products Disposal System	Yes
Wilsons	Security Facility Wide	Yes
Healthscope Legal/Insurance	Industrial Special Risks Insurance (Material Damage and Business Interruption)	Yes
AON/Zurich Australia Limited	Public and Products Liability Insurance	Yes
AON/Lumley Insurance (Melbourne, Australia), Marketform Ltd London, QBE Europe, Catlin Australia	Medical Indemnity Insurance	Yes
AON/QBE Insurance Group (Lead Insurer), Vero Insurance Limited.	Professional Indemnity	Yes
BGIS - current	Air Conditioning	Yes
Frostline- 2-year agreement current	Blood Fridge	Yes
BGIS - current	Carpet & Vinyl & White Rock	Yes
Nationwide Security	Security Cameras/Duress	Yes
IT services desk - Healthscope	Internal phones	Yes
BGIS/Raulands	Nurse Call	Yes
BGIS	Painting	Yes

Provider	Description of Services	Verified During Assessment
Daniels	Sharps Disposal	Yes
BGIS	Thermostatic mixing, general plumbing, hot water units,TMV's	Yes
Daniels/Clearaway	Waste Management	Yes
BGIS	Maintenance	Yes

Ringwood 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 national governance structure of Healthscope services was well articulated by RPH staff who use local frameworks and committee structures to provide local leadership. Senior staff were able to describe the national\local approach very well. Strategies and clinical priorities were clear and communicated to staff at all service areas. A range of key performance measures (including ACHS clinical indicators) are regularly reviewed and benchmark reports across all Healthscope hospitals were available to view. The committee structure at RPH is used to monitor care effectiveness, incidents, and audit results. The range of documentation viewed by assessors confirmed that the requirements of the ACSQHC Checklist for Assessors – Reviewing information accessed and actioned by the Governing Body, had been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
Healthscope national has just endorsed its Reconciliation Action Plan (RAP) which applies to all Healthscope services. This is an "innovate" plan and builds on the previous "reflection" RAP. Launch of the new plan is imminent. Admission numbers for Aboriginal people at RPH are low (0.16% in 2022), although there has been an increase in the 2023 YTD figures to 0.19%. The local community identifies a 0.6% Aboriginal and Torres Strait Islander population (ABS data).	
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 documented Clinical Governance Framework is in place for all Healthscope Hospitals. This is supported by the RPH Clinical Governance Plan. Senior staff in key clinical governance leadership roles were able to describe the organisation's Clinical Governance Framework in detail. There were a number of examples provided by staff which demonstrated how this is used operationally to guide and govern decision making.	
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	
RPH has an Aboriginal and Torres Strait Islander Engagement Plan 2021-2024 in place. This supports the RAP. There are detailed actions, deliverables, timelines, and responsibilities included in the plan. It is anticipated that the recent recruitment of Aboriginal consumer consultants will further support the implementation plan. These individuals have been recruited following receipt of the Aboriginal specific feedback survey sent out post discharge.	
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	
Assessors undertook reviews of relevant committee minutes, reports, and planning documents. This material, along with interviews with key senior staff, confirmed that clinical effectiveness and issues of safety and quality are key factors in RPH's business decision making.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
A review of documentation, reinforced by Assessor observations and interviews with staff, verified that staff at RPH work within the local governance framework. Clinical safety and quality responsibilities were clearly articulated in position descriptions and through mandatory training. RPH staff confirmed they understood these responsibilities and were able to explain how RPH monitors and evaluates performance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation, and jurisdictional requirements	
Comments	
Staff at RPH have access to a comprehensive range of policies, procedures, and protocols which guide practice. This is a mix of documents produced by Healthscope nationally which apply to all services, and some local (RPH only) policies\procedures. These are all available electronically. Documents are maintained under various categories e.g., Administration. While there is no overall search capacity, once in the appropriate section the search function can be used. Staff interviewed understood and demonstrated that they could effectively use the system. Policy documents are in a standard format, reference legislation and are of professional standards. Compliance is monitored through incident reporting and audit.	
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	
RPH has a quality action plan in place which identifies key KPIs and quality targets. A Healthscope national target is used for many of these KPIs, and outlier results remain on the plan until improvements have been achieved. The service uses the eQuaMS platform to maintain a register of Quality improvement activities, compliance data and performance results. This is accessible to all senior staff. Data is presented to committee meetings, including consumer meetings, and on Quality Boards in each ward area. Assessors noted that this was in a very professional format.	
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	
Reports on the various aspects of RPH's safety and quality system are provided to Healthscope Board (National), Senior staff, the workforce generally, consumer consultants and patients. Ward Quality boards are in place for patient viewing and these had consumer input into their design and are customised for the role of the ward. RPH also publishes a significant amount of data on its public web page including rates of incidents across a number of domains (including medication, falls, and infections).	
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	
RPH has a Risk Management and integrated Risk Register Policy in place. The risk register is a module of the RiskMan system. It is regularly reviewed, and additional risk added as needed. Residual risk and the control trend are included in the register as well as the responsible executive member. Assessors noted that there are no risks rated higher than moderate on the current register. Controls to minimise internal and external emergencies are in place, as well as clearly defined responses should these emergencies occur.	
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	
RPH uses the RiskMan incident reporting system and has policy in place to categorise all incidents, which are reviewed and further investigated where required. Near misses were reported and this is indicative of a reporting culture at the health service. Analysis and feedback are provided for incidents. Committees review incidents relevant to their area of responsibility, monitor trends and use the data to inform practice improvements. The community has access to aggregated incident data on the RPH public web page.	
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	
RPH has Open Disclosure as one of its mandatory training requirements. Sixty staff have been identified as required to complete the training and compliance is 100%. Senior staff are available to assist with the Open Disclosure process. How and why Open Disclosure occurs is monitored.	
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	
Feedback is regularly sought from patients via questionnaire. This is often administered by the Consumer Consultants who visit patients during their treatment stay. Similarly, feedback is regularly sought from RPH staff. All feedback is analysed, trended, reported, and used to inform quality improvement activities.	
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	
RPH has in place a complaints management policy and processes. Complaints were clearly treated very seriously and investigated thoroughly. Assessors used a complaint they had viewed as the topic for an in-depth review. Senior staff described the process used, demonstrated the communication used with the family and the records kept. The quality improvements that were put in place post complaint were communicated to the family and they chose to be directly involved in reviewing the new publication pack that was one of the planned improvements.	
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	
Assessors viewed information provided by RPH which demonstrated the diversity of patients as well as that of the local community. This has allowed them to establish their patient profile which includes gender, age, ethnicity, and languages spoken at home. Staff were able to demonstrate how they used this information to identify patients who may be at higher risk. For example, 23% of patient admissions were for patients over 80 years of age, which indicates that they may be more at risk from falls.	
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	
RPH has a paper-based health record, and this is readily available to clinicians at the point of care. The health information team ensure the record is available for each clinic that is held and for all inpatient interventions. The records reviewed were in extremely good order. Records are maintained securely, both at RPH and in an offsite storage facility. Documentation audits are completed, and results used to improve the quality of record keeping. Duplicate UR numbers were reported to be less than 1%. Assessors noted the recent work undertaken to improve the timeliness of completion of medical discharge summaries.	
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	
Clinical information (discharge summaries) is submitted into the My Health Record system. National patient and provider identifiers and standard terminologies are used. The requirements of Advisory 18/11 have been met.	
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	
Healthscope (including RPH) is progressing integration of the clinical information in healthcare records with the My Health Record System. Information that is provided is regularly reviewed to ensure accuracy, completeness and that it complies with legislative requirements. The requirements of Advisory 18/11 have been met.	
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	
Orientation is provided to all RPH staff, executive and volunteers. There are responsibilities for safety and quality included in position descriptions. RPH also requires staff to complete training on various components of quality and safety. For example, code of conduct, patient centred care and working with respect are all mandatory for RPH. Compliance is monitored and at the time of assessment was 99%, 100% and 98% respectively.	
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	
RPH resources an education position and part of this role is to administer a training needs survey yearly. This allows staff to provide feedback on the training that has been provided as well as identify any training needs, they have. The 2023 survey identified a cohort of staff who wanted an update on post operative care. This was sourced and actioned for nursing staff. Records of attendance at training are kept. These bespoke training sessions complement the mandatory training and competencies that RPH require completed.	
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	
An Aboriginal and Torres Strait Islander Cultural Awareness program as well as Cultural Diversity program is part of mandatory training requirements for staff. RPH has also had a strong focus on correctly asking the question - are you of Aboriginal or Torres strait islander descent? Training records are monitored for compliance and were reviewed by assessors.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Comments	
Staff Performance Reviews are conducted at RPH. Staff described the performance review process and their role. As part of this process completion of mandatory training is monitored and additional training needs are identified.	
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	
RPH uses the C Gov electronic system to maintain the relevant paper applications for credentialing by medical officers and dentists. This platform is also used to re credential the practitioner. It is directly linked to the AHPRA web site and so if any changes to a practitioner's status is recorded it appears in the Healthscope system. The General Manager and the Medical Advisory Committee (MAC) approve a clinicians credentialing and scope of practice for medical practitioners and dentists. There is a process to provide interim credentialing if required. The C Gov system is directly linked to the RPH patient registration system. This means that nursing staff can check the scope of practice for each clinician. Assessors reviewed the documentation for surgeons operating during the assessment and these were all complete. Assessors noted that medical officers are not required to provide a criminal record check as part of their credentialing application. Processes for credentialing nursing and allied health staff are in place. The MAC approve new techniques in conjunction with the general manager.	
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	
RPH completes regular checks to ensure that clinicians are credentialed and registered (via the link with AHPRA). It was apparent that the staff member allocated to the task of maintaining the system regularly monitored the effectiveness and was skilled in ensuring that medical officers and dentists were credentialed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	
Staff interviewed by the Assessors were able to articulate their roles and responsibilities for quality and safety. In essence all staff indicated it was their role to provide safe and effective care, regardless of their actual role. Responsibilities are included in position descriptions and in agency contracts. Staff are also advised of their responsibilities during orientation.	
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	
Assessors determines that supervision arrangements are in place for clinicians. This included an active role played by the Medical Advisory Committee (MAC) in working with clinicians if there are any training or improvement issues identified. The MAC also ensured that afterhours access was available for medical advice and the nursing division had an allocated after hour nurse.	
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	
RPH and Healthscope provide clinicians with access to best practice guidelines and contemporary evidence. Policies and procedures include links to evidence. The ACSQHC clinical care standards have been adopted where appropriate. RPH complies with Advisory 18/12.	
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	
RPH uses clinical indicators, including ACHS indicators, to monitor variation in practice. There are also internal benchmarks between Healthscope services. The MAC provides and M&M function and patient outcomes are extensively reviewed as part of this process. Any issues identified are addressed to improve practice. Where variation is identified a risk management approach is adopted to minimise patient harm.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices, and other infrastructure that are fit for purpose	
Comments	
The facilities at RPH were observed to be in good order and well maintained. There is an active hazard identification process with prompt follow up from key staff when a hazard is highlighted. A selection of maintenance contracts was reviewed and there is regular testing and compliance monitoring of building infrastructure and equipment. A number of the mandatory training programs target the safe maintenance of the building. These include room cleaning, safe handling of chemicals, as well as cleaning, linen, and waste during COVID 19.	
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	
RPH identifies that some patients with cognitive impairment are at risk of unpredictable behaviours. There are processes in place to ensure these patients are provided with treatment in appropriate rooms. There are a number of quiet spaces that have been created to ensure appropriate calming and private areas are available. This includes a recent improvement when an unused gymnasium area was converted into a patient sitting area.	
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	
Assessors toured all areas of RPH. Signage in and around the service was clear and fit for purpose.	
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	
Assessors noted that flexible visiting arrangements are in place for patients who are admitted overnight.	
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	
Throughout the buildings at RPH there were tabletop Aboriginal flags, posters and artwork on brochures and documents. The service took delivery of some commissioned artwork during the assessment. A local Aboriginal artist had been engaged to create a series of paintings that reflected the services provided by RPH. Each piece was to be hung in the area which the painting best reflected.	
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	
RPH has in place a detailed Consumer Partnership Plan which details specific strategies for the organisation. Assessors met with enthusiastic Consumer Consultants who discussed the many activities they have been involved in. Notably they are an important link with patients while receiving care and gather feedback from them in person. There is a Consumer Advisory Committee which has a very close working relationship with the Quality team and Executive staff. The restrictions associated with COVID have meant the committee has not met as intended but is now re convening. This committee has recently recruited two members who identify as Aboriginal. A detailed Consumer Toolkit is in place. Consumer consultants also play a role in education and speak at all staff orientation sessions.	
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	
RPH staff and consumer consultants confirmed that the organisation aims to improve partnerships with consumers at all levels. The Assessors observed how consumer engagement strategies are monitored and how the organisation reports on partnering with consumers. The Consumer Partnership Plan includes proposed actions which are monitored, and progress noted as part of the updating of the plan document.	
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	
RPH uses the Australian Charter of Healthcare Rights which form the basis of their brochure "Rights and Responsibilities, important information for patients". This document was available throughout the hospital especially at the entrances. It is also on the RPH web site. The document is available online in English, Greek, Chinese and Italian.	
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	
Policies, procedures, and forms are available to support the obtaining of informed consent at RPH. Staff interviewed understood their responsibilities with respect to informed consent. A process is in place to obtain a patient's consent to the costs associated with care. Assessors spent time with the admissions staff and observed how this was confirmed before admission and again at the time of patient presentation to the hospital. The consent policy and processes comply with legislation, and reference best practice. The requirements of Advisory 18/10 have been met.	
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	
Health record documentation, policy and procedures demonstrated that RPH has sound processes in place to confirm a patient's capacity to make decisions. A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care. A process to document a substitute decision-maker where present was seen in the health record.	
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	
Given the services offered at RPH, Advance Care Plans\ Directives are used regularly. Discussions with staff advised that processes were used to confirm if a directive existed and ensure that it was followed. Similarly, the role of the substitute decision maker was clearly identified, and they were involved in care planning and decision making when needed.	
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, consumer consultants and patients were able to describe to the Assessors how patients are actively involved in their care. The Consumer Consultants noted that they do act as an advocate when required to support patients. They remarked that staff were always responsive to any issues that they raised on behalf of the patient.	
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	
RPH has a number of their publications and forms available in languages other than English. There is extensive use of QR codes to access translated documents. Language spoken at home is monitored on admission and while the majority speak English (97.9%), Cantonese (0.75%), and Italian (0.12%) were also reported. Documents are available in both these languages.	
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	
Consumer Consultants are actively involved in reviewing publications created by RPH staff. An area the consumers consultants had been involved in from inception was the creation of the information boards at the bedside. It was evident that staff at RPH also understood that Health literacy included their approach to patients and carers.	
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	
RPH clinicians were able to articulate how they effectively partner with patients in their care. Patient satisfaction with the information provided to them is monitored in real time by Consumer Consultants. Satisfaction is reported as high. Patients who were interviewed by Assessors confirmed that information was provided in a suitable format and manner. Consumer Consultants reported their involvement in the development of the "Discharge checklist and information envelope" provided to patients.	
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	
Assessors met with Consumer Consultants who are members of the Consumer Advisory Committee (CAC). They were able to confirm the role they have played in the health service, including governance and evaluation. Examples of how feedback from patients, via Consumer Consultants, that had resulted in changes to services\care were provided. RPH is actively pursuing the inclusion of culturally diverse representatives on the CAC. Two individuals who identify as Aboriginal have been recruited following invitations on the satisfaction survey.	
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 organization	
Comments	
Consumer Consultants at RPH described how they attended orientation and had the resources of a Consumer Toolkit to support them in their roles. They also reported strong support from members of the RPH executive team.	
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	
RPH does not have a local Aboriginal community organisation specifically but does work with VACCHO to help identify and meet local health needs. Nationally the reconciliation action plan identifies priorities for Healthscope generally. There has been a focus on asking the question for all patient to assist in the identification of Aboriginal patients. The Director of Nursing acts as liaison for Aboriginal patients admitted to RPH. The service celebrates days of significance. Plans are in place to develop a reflection space when a suitable location can be identified.	
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 Consultants advised assessors that they presented at all staff orientation sessions on consumer involvement at RPH. In addition, the experiences of individual consumers are used for training staff on condition specific care.	
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	
The National Healthscope and Ringwood Private Hospital (RPH) Infection Control and Management policies have been updated to incorporate the requirements of the 2021 edition of the Preventing and Controlling Infection Standard and compliant with Advisory AS20/02. RPH has the required policies and procedures to support the safety and quality system for infections prevention management and treatment of healthcare infections and Antimicrobial Stewardship consistent with the Clinical Governance Standard. There is an Infection Control Risk Management Plan and annual calendar in place which reflects the requirements of the NSQHS Standards and is updated annually. Risks are identified, reviewed, and monitored. Training is identified through audit processes and provided to all staff according to training timeframes or as necessary. Monitoring for the compliance of training is undertaken by Ward champions and overseen by the Infection Prevention IPC Co-ordinator and the Infection control Committee and reported through the governance structure to executive and national board. The evidence provided multiple examples of training, compliance audits and evaluation.	
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	
The Infection Prevention and Control system across RPH is effectively supported by the multidisciplinary Infection Prevention and Control Committee (IPCC). The Infection Prevention and Control system is also supported through the Healthscope contract with Healthcare Infection Control Management Resources Pty Ltd (HICMR). It is evident that there is effective monitoring of infection prevention, primarily managed by the IP team with a significant number of reports provided for review at assessment. There are a range of online education programs in place and available to all clinical teams across the group, including IP&C, Hand Hygiene, ATT, and PPE with data indicating excellent compliance with attendance at education sessions. A comprehensive auditing schedule is in place with results reported both locally and aggregate data provided through to the governance structure. There are nominated department IPC Champions to support the program. Infection control risks and outcomes are recorded in RiskMan, monitored by the IPCC, and are reported through the governance structure to the RPH Executive and Healthscope National. Infection prevention and control is a standing item on the RPH Quality Meeting agenda which is attended by the Infection Control Co-ordinator (ICC).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.03	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources	
Comments	
There is a comprehensive schedule of auditing for infection prevention and control systems and audit results are provided to individual units and aggregate data is provided through the governance structure. Strategies are in place to improve any areas with less-than-optimal performance. Infection control and prevention and AMS are discussed at relevant committee meetings and strategies are documented to improve performance where gaps are identified. There were no COVID cross infection within the sites, due to the thorough screening and infection control strategies in place. Covid-19 positive patients were treated throughout the pandemic and continue to be treated with appropriate strategies to safeguard both other patients and staff. RPH participates in national, jurisdictional and peer benchmarking surveillance activities through HICMR and the Australian Council on Healthcare Standards (ACHS) Clinical Indicator Program. The assessment team observed a consistent and comprehensive infection prevention program in place and were able to verify a range of successful improvement activities across the organisation.	
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	
Policy documents about IP&C and standard and transmission-based precautions are consistent with the Australian Guidelines for the Prevention of Infections in Healthcare. Training includes infection prevention and control practices and principles, Hand Hygiene, aseptic technique, and the use of PPE. All sites have signage and processes that reflect the current requirements for standard and transmission-based precautions. A surveillance program is in place, monitored and data collect on antimicrobial use as well as broader infection control surveillance data. Reports on healthcare related infections and antimicrobial use are provided to clinicians and reported up through the governance committees. A diverse range of consumer reviewed and endorsed infection prevention and control literature is used to assist patients and visitors to understand infection control risks and responsibilities. The information ranges from the disease or organism specific to the requirement for prophylactic antibiotics. The consumer information is also readily available on the RPH web page, in pre-admission information and at the point of care, and is also used when managing outbreaks to ensure that all patients and families have best practice information.	
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
Policy and procedure documents outline the assessment of infection risks and implementation of standard and transmissions-based precautions to manage these risks. Entry to facilities requirements have now been relaxed though current health status questions and the wearing of masks remain in place should staff, patients or visitors wish to. Patient referrals, discharge summaries, medical records, transfer forms, and clinical handover identify infectious risks. Observation at all the facilities identified that all the relevant equipment which included PPE and signage was available and used. Policies, procedures, and guidelines for standard and transmission-based precautions used are compliant with the Australian Guidelines which are reference. Personal Protective Equipment is available and used with clear guidelines for implementing standard or transmission-based precautions available. Audits demonstrate compliance. Standard and transmission-based precautions, consistent with national guidelines, were observed to be in use across RPH. Standardised signage for transmission-based precautions was seen by the assessment team, as was appropriate Personal & Protective Equipment (PPE) relevant to the precautions required. Monitoring of compliance with standard and transmission-based precautions occurs in line with the IPC audit schedule and is reported at the IPCC. There are hand hygiene stands and posters in public areas, and alcohol-based hand rub is available to the public and is in all clinical areas and in each patient, room close to the patient. The use of Hand Gel is actively promoted, readily available and used by staff across the unit and in client rooms.

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	
RPH policy and processes for the management of organisms-specific risks, are in place and are consistent with jurisdictional and Public Health advice. A COVID Plan was developed with reference to the Australian Government COVID guidelines. This included the development of operational guidelines for the management of COVID 19. RPH was identified as a COVID free hospital, however due to the client cohort did and still do admit covid patients and managed them appropriately. Client Pre-admission information includes advice on appropriate admission requirements and any infection or Covid 19 precautions. Actions included staff education and monitoring of infection prevention including the use of PPE. While covid restrictions have been relaxed masks and hand gel are freely available for use by both staff, patients, and visitors.	
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	
Policies and procedures are available for implementing standard and transmission-based precautions and all staff (including non-clinical staff) are provided with education appropriate to their role. All staff spoken to were able to confirm their understanding and use of these measures and risk screening procedures. Facilities can effectively manage infection risks and environmental management and cleaning practices are consistent with policy. All patients with infections are flagged on the electronic patient administration system. Communication of a patient's infectious status is included at all transfer of care / handover points and compliance is monitored. Patients, carers, and families are alerted to precautions that are required. Brochures, posters, and Internet sites are used to inform and advise patient's families/carers on infection control and management processes if this is appropriate.	
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; workflow 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 of relevant details of patients' infectious status is included on the patient transfer form. At the time of a verbal handover infectious status is also communicated. Risks are evaluated throughout the episode of care, with reporting, documentation and management of any communicable disease identified. Patient welfare, equipment, environmental measures, and environmental and terminal cleaning are all areas identified and managed. During assessment appropriate environmental cleaning appeared to be occurring across all sites, issues have arisen in the past and while compliance with requirements has risen considerably this is an area for further vigilance and review to ensure appropriate cleaning occurs consistently.	
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	
Policies and processes are in place to collect and respond to data on infections that impact on patients and the workforce with communication processes in place to communicate infectious status to all sites. Current information appropriate to patient and family needs is available and provided both verbally and in written form. Information is also available in different languages and through interpreters appropriate to the patient cohort. of a patient's infectious status is included at all transfer of care / handover points and compliance is monitored. Electronic Medical Record and paper-based records clearly identify infectious status of the patient with alerts visible throughout the patient treatment admission.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance	
Comments	
The Hand Hygiene program is consistent with the current National Hand Hygiene (HH) Initiative and jurisdictional requirements. Regular compliance and observational audits are undertaken and provided to staff, through to the governance structure and visually through the quality boards in ward areas and dashboards to committees and executive. Current compliance rates are 96% and well above the compliance target of 85%. Any areas with identified lower levels and any areas of drop off are identified and remedial action undertaken. All employed and contracted members of staff are required to undertake online learning for HH with contracted VMOs signing declaration of competency. Hand Hygiene gel and instructions for use is available and continues to be used throughout the hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11	
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	
Procedures that requiring Aseptic Technique have been identified and the workforce complete a competency training package which aligns with current legislation. Auditing monitors compliance and if there is identified non-compliance action plans are developed, implemented, and managed well. Processes for aseptic technique (ANTT) are in place. Staff who are required to use aseptic technique are appropriately trained with regular audits undertaken, with a good compliance of the requirements of aseptic technique of over 96% of all RPH staff. Online training is available to all VMOs with those involved in high-risk procedures completing this. Observational audit of VMO demonstrated 99% compliance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
Training and assessment for the management of invasive devices is available and undertaken by staff who are required to utilise these devices, and these are aligned with the current legislation. Associated infection rates are monitored and reported with an identified 96% compliance. The Healthscope Cannulation form is an assessment and decision-making tool that clearly identifies assessments made and tracks the time a patient's IV devise has been in situ.	
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	
The clinical and environmental processes in place across RPH have ensured infection rates remain low especially during a refurbishment. The assessment team were impressed with the standard of environmental cleaning observed in all clinical and non-clinical areas with evidence of a culture of pride in maintaining a clean environment. Cleaning schedules, including extra requirements for potentially infectious areas, are in place, including terminal cleaning with cleaning staff receiving appropriate training in cleaning procedures, HH and IP&C training. Areas falling below the identified target are identified, advised and work plans developed. Results of all audits indicate levels of compliance and are reported through the governance structure. An audit schedule is in place with results monitored by the IPCC. Legionella testing and risk mitigation is in place and as is annual High Efficiency Particulate Air (HEPA) Filtration testing. Maintenance schedules for buildings, equipment furnishings and fittings are in place.	
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	
RPH has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that is responsive to novel infection risks and pandemics. At a national level, all new products are reviewed and assessed for infection related risk. Maintenance is both scheduled and responsive to failure. A gap analysis against AS/NZ 4187 has been completed at both a national and national level with an action plan identified and implemented. RPH was identified as compliant with AS/NZ 4187.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers, and patients	
Comments	
There is a comprehensive workforce immunisation program in place that is consistent with the current edition of the Australian Immunisation Handbook and complies with the jurisdictional policy and national guidelines. Immunisation status is captured during the recruitment process with a staff health data base containing workforce vaccination records and for identification of ongoing required vaccinations. There is an annual influenza vaccination program with rates currently at 100% for staff, with processes in place for those unable to be vaccinated. A COVID-19 vaccination program is in place to ensure staff are fully vaccinated.	
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
Policies and processes are in place at a local and national level consistent with the Australian Guidelines for the Prevention and Control of infections identifying risk-based processes to be followed for preventing and managing infections in the workforce to enable the continuing provision of ongoing service. Records of workplace allocation for appointed staff with a program for workforce screening and workplace exclusion is aligned with Healthscope National guidelines. There are well tested outbreak management plans in place led by the Executive team with clear guidelines for staff in relation to COVID and other infectious diseases, with advice available on what to do. Processes are in place to manage the ongoing management and treatment of COVID positive patients. While covid restrictions have been eased masks are still available for staff, patients and visitors should they wish to wear them with gel stations in all ward areas and across the facility. There is an employee immunisation program that complies with national guidelines and jurisdictional policies. Staff immunisation information is collected prior to commencement and is reviewed by the ICC. Evidence was sighted by the assessment team demonstrating good compliance of staff with completed immunisation in high-risk clinical areas. An annual influenza vaccination program is in place and is actively progressed, with participation rates reported to the IPCC, executive groups, and the Quality Committee. There are evidence-based policies and procedures for the prevention and management of occupational exposures available for all members of employed and contracted staff. Compliance audits are conducted which include the use of Personal Protective Equipment (PPE) and the safe use and disposal of sharps. Occupational exposure incidents are reported through RiskMan and are monitored by the IPCC. Evidence was presented of the management of an exposure incident including the initial management, ongoing support, and educational learnings. All patients with infections are flagged on the electronic patient administration system. The patient's infectious status is communicated during clinical handover, and whenever responsibility for care is transferred within or between departments or facilities.

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	
Reprocessing of reusable medical devises except for colonoscopy scopes is currently undertaken by another Healthscope facility due to remodelling of RPH CSSD premises. Processes are in place for the cleaning, packing, safe transport of used equipment and sterilised equipment between the two facilities. Storage of sterile stock across BPH meets all requirements. The contracted facility is compliant with the requirements of AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations and the Australian Commission on Safety and Quality in Health Care's Advisory (ACSQHC) A18/07 well understood. There is a formal training program conducted by HICMR with annual audit of compliance that is consistent with industry standards, for all staff involved in the reprocessing of reusable medical devices, with competency assessments conducted regularly. A tracking system is in place for the tracking of all reusable devises and linking sterilizing, instruments, trays, and patients. Auditing of all areas of the reprocessing process is undertaken and recording of processes, equipment and check maintained demonstrating excellent compliance. Progress is regularly monitored by the IPCC and the Executive Committee. All instrument cleaning and sterilisation equipment is regularly serviced, and appropriate monitoring is in place. Cleaning service audits are conducted regularly and monitored by the IPC coordinator and the IPC committee.	
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	
RPH antimicrobial stewardship program is evidence based and includes the components from the Antimicrobial Stewardship Clinical Care Standard with endorsed therapeutic guidelines available. Strategies are in place to ensure audits are used to promote quality in the use of antimicrobials. A gap analysis has been undertaken with a well-structured governance framework in place for strategy implementation, monitoring, and reporting. Training of staff, guidelines for antibiotic decision making and prescription, access to Infection Control Specialist have ensured good policies, guidelines and processes are in place.	
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	
Improvements in compliance with guidelines and appropriate dosing for antimicrobial medications are reported to the Infection Control Committee and the MAC committee. Surgical prophylaxis reports are also reviewed by MAC. Appropriateness and usage of antibiotics are monitored and reported to the Infection Control Committee, the Clinical Governance and MAC Committees. The audit results of 84% demonstrate appropriate antibiotic used and a reduction in the amount of antibiotics given. The requirements of the Advisory AS18/08 have been met.	
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	
RPH has policies and procedures tin place that define medication management. A risk management approach is used to minimise incidents related to medication. Healthscope staff receive training in medication management that supports their roles in the health service. A number of medication related training modules are part of the mandatory suite of staff training. This includes training for housekeeping staff on the safe handling of cytotoxic waste. A clinical pharmacist is actively involved in all reviews. An approved formulary is in place. RPH usually provides an onsite compounding service for oncology patients, but this was suspended at the time of assessment, following a decision by Healthscope nationally.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Comments	
The RPH medication safety committee oversees the analysis of all incidents and identified risks associated with medication management. This committee reports to the Quality and Risk Committee as part of the RPH governance structure. A number of medication related KPIs are monitored across the Healthscope services and benchmarking occurs across these services. Assessors were able to assess an incident involving medication in detail and noted that this review was well structured, timely and was used to generate practice improvement. Open Disclosure was carried out with the patient involved.	
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	
RPH involves patients in their care by providing access to a clinical pharmacist as well as appropriate information about medications and treatments. This was particularly evident with oncology patients observed during the assessment. A report on medication incidents is provided on the RPH public web page.	
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	
Responsibilities for medication management is defined in RPH policy. Nursing staff oversee the medication storage at RPH, although a clinical pharmacist is available if required. The clinical pharmacist confirmed the collegiate relationship she had with nursing staff. It was apparent that this was an effective working relationship.	
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	
All admissions to RPH are planned and this facilitates the clinical pharmacist's active role in taking and recording the medication history on admission. Where this does not occur, it is completed by nursing staff. Assessors confirmed this process when interviewing clinical staff and reviewing health records.	
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	
Assessors reviewed health records and were able to confirm that current medications are reviewed for accuracy on presentation. Observations of staff interactions with patients confirmed that this was checked again at point of care.	
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	
RPH has in place a process to ensure that medication alerts, including allergies and adverse drug reactions, are documented. This was confirmed in the health records reviewed.	
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	
All adverse drug reactions are recorded in the patient health record, and via the incident reporting system.	
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	
Discussions with staff including the Clinical Pharmacist confirmed that adverse drug reactions that met the defined criteria were reported to the TGA.	
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	
Medication reviews are undertaken by the clinical pharmacist in most instances, and this may be done in conjunction with the medical officer. These are documented in the health record. The clinical conditions treated at RPH means that minor adjustment to a patient's medication regime is common.	
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	
Written information for patients on specific medications is available. Patients reported being able to access this information and also understand what was provided to them. Patients also noted that they were always able to talk with staff if they had any queries or concerns about medication.	
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	
Medication lists are available to patients where required on discharge. Discharge summaries included a medications list and rationale for any changes. Patients receiving chemotherapy were provided with information on possible side effects and how to manage these.	
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	
RPH makes available to clinicians' information and medication management support tools. This was confirmed in discussions with the clinical staff who reported that they were able to easily access 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	
RPH monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage of medications. This involves all staff including environmental staff who were well versed in the correct storage and disposal of cytotoxic waste. Assessors observed all clinical staff checking medications in the DD storage areas and noted that this was done strictly with no interruptions.	
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	
A high-risk medications register is in place at RPH. These medications are regularly audited to confirm that storage and use is within RPH guidelines.	
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 provision of safe Comprehensive Care is governed by National Healthscope evidence-based policies and procedures. RPH has developed local policies were required and has processes in place to manage clinical risks. The risk register demonstrates documentation of risks associated with providing Comprehensive Care and mitigation strategies that reduce the risks. Monitoring of events such as incidents, adverse events, and patient feedback are managed through the quality and risk systems, reported to the Patient Care and Clinical Committee, and included in the National Healthscope auditing and feedback system. A range of mandatory training is required for staff regarding comprehensive care, and the compliance rate for all training attendance is in the high 90% range. The establishment of education huddles during handover, an updated information folder and a communication book which are working well is a good initiative.	
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	
A clinical governance quality and safety plan has been developed at RPH with an audit schedule incorporated. Monitoring of the audits regarding comprehensive care is in place with a range of KPIs collected and reported. The audit results are reported to the results to the Clinical Committee, the workforce and all outcomes from the comprehensive care standard are reported to Healthscope National for analysis and feedback. Where results are outside the target an action plan is developed. An example of this is for the period October – December 2022 falls were slightly outside the target. A post fall huddle was introduced, a shift planner incorporating tidy rounds and participation in the Healthscope Falls Webex occurred. Falls rates have been reduced and are now within the target.	
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	
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the Assessors how they achieve this, and patients reported that they felt actively engaged in, and informed about their care. The assessors witnessed patient involvement in their care during handover with consistent use of the patient information boards. During patient interviews with the assessors, consumers spoke about the communication and actions between patients and staff and about participation and shared decision-making in their care.	
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	
Healthscope and RPH policies, plans and procedures support clinicians in developing comprehensive plans and treatment for their patients. Throughout the visit, assessors noted easy and effective communication between doctors, therapists and nurses that was supported by clinical notations. The provision of safe Comprehensive Care is directed through Healthscope and BPH evidence-based policies and procedures that are reviewed regularly and as needed to ensure the best possible Comprehensive Care is maintained. The clinician responsible for overall care is noted on the patient board as is the nurse for the shift.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.05	
The health service organisation has processes to a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
Clinicians are provided with Healthscope endorsed tools that comply with Advisory AS18/14 "Screening and Assessment of Risk of Harm" and ensures comprehensive screening processes are implemented. Documentation audits identify gaps. Multidisciplinary meetings to discuss care of the patient and team time out are conducted. Position descriptions were viewed by the assessors that define the role of clinicians, RPH also conducts audits of position descriptions with 100% of those audited defining the scope of practice and responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Healthscope endorsed the comprehensive care plan in 2019 and this was implemented at RPH with education for staff provided. There are also a number of toolkits available to assist staff to work and plan to provide collaborative care for the patients including the cognitive impairment toolkit and discharge planning tools electronically. PCOC documentation, education and tools are used to provide comprehensive car where appropriate.	
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 of this was sighted in clinical documentation. The care plan is informed by the screening processes and developed by the multidisciplinary team in partnership with the patient and family towards meeting the patient's goals. The plan in partnership with the patient identifies and documents the support people who are to be involved in planning and implementing strategies to reflect the patient's individual needs. Plans for discharge are discussed on admission. RPH completed an audit to verify the compliance with comprehensive care plans in 2020 and achieved 100% compliance with patient having a comprehensive care plan. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. Validated assessment tools are in place to ensure thorough assessment is undertaken with management plans established. The organisation is compliant with the requirements of Advisory AS18/14	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
Demographics record the numbers of Aboriginal and Torres strait Islander peoples accessing the organisation are very small but predicted to grow. The organisation demonstrates that processes are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. This is audited, and compliance is 95%. Staff were able to describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin. There is a system in place on PAS to enable patients to identify as Aboriginal and Torres Strait Islander with training regarding this being available for staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
Policies are available at RPH regarding Advance Care Planning. Patients are asked at preadmission and on admission if they have an Advance Care Plan (ACP). With a copy attached to the patients clinical file if they have one.	
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	
Patients have a full history on admission and undergo a comprehensive screening process which is repeated when clinically indicated. Screening processes includes cognitive impairment, medication management, malnutrition, falls, VTE, mental health, behavioural and substance withdrawal, and skin assessment. Risk screening processes are audited, and reports are provided through the organisation's governance structure. The Assessors were invited, with patient permission, to observe the nursing assessment process. Thorough assessment was noted with patient participation allowing for the expression of their goals of care and any concerns they were experiencing. A limited review of clinical documentation by the Assessment Team members reinforced this. 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	
Screening assessments occur on admission, weekly or if there is a change in a patient's condition. Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Documentation audits demonstrate a high level of compliance with screening, assessment, and care planning processes, with confirmation of the results of assessor findings when sighting the clinical records. Screening and clinical notes are multidisciplinary with clear indication of specialties assessing or documenting on the patient.	
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	
Risk screening for all patients is documented in the Comprehensive risk screening document. A comprehensive daily care plan is also completed for each patient. An alert sheet is available at the front of the clinical notes to record any alerts. A recent audit indicated that 100% of notes audited for a comprehensive care plan and 99% for a daily care plan.	
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	
The comprehensive care plan is sufficiently detailed to provide an individualised care plan that provides the complexity of the patient's health and risks of harm. Education is provided to staff regarding the comprehensive care plan and of the risks of harm. A Safety during you stay brochure is also available the provides information regarding all aspects of comprehensive care for the patient which informs them that they will be asked about their goals and processes available to them should they or their family be worried about any aspect of care. The care plan identifies the patient goals and actions required to provide treatment and care to each individual patient. Clinicians and patients were able to describe the role patients, carers and families play in the planning and delivery of care and in determining patient centred goals and how it aims to best meet their specific needs. A review of clinical documentation by the Assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. Members of the assessment team witnessed interactions between staff, patients, their carers, and families that demonstrated this partnership in care and decision making. Care plans reflect contemporary evidence based best practice principles. The requirements of Advisory AS18/15 and Fact Sheet in relation to the identification of patient goals of care 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	
Healthscope and RPH policies support practices that involve patients, carers, and staff to use the comprehensive care plan. The Safety during your stay brochure explains this to patients. The plan is regularly audited to monitor this. If there is a change in condition reassessment occurs and documented in the clinical record. Patients, their carers, and families were able to articulate their level of engagement in their care and expressed satisfaction that they actively participated in decision making at all points of care and transition. Goals of care are monitored, and care planning modified in response to a 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	
RPH implemented a Last Days of Life resource folder in 2020 which details the policies relating to end of life and provides resources for staff.	
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	
Clinicians have access to specialist palliative care off site if required, this includes medical and social work services. Details of the contacts are provided in the last days of life folder and on webPAS.	
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	
Patients are asked on admission if they have an advance care plan, and if so to bring it on admission for inclusion in the healthcare record. If not, they are informed of the process, and if they wish are supported by clinicians in the process of documenting their plan. A review of clinical documentation confirmed that advance care plans received from the patients are placed in their clinical record. Clinicians who were interviewed could describe the process in place to ensure that patients with an advance care plan are identified, and that care is provided in accordance with these plans.	
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	
Staff providing end of life care are provided education via the PEPA course and have access to the Employee Assistance Program (EAP). Debriefing and one on one support are undertaken within the nursing team.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	
The RPH with the help of consumers has developed an End-of-Life Care Survey for Families that has recently been conducted but results were not available, however informal review and verbal feedback from families demonstrated a high level of satisfaction with care given.	
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	
Healthscope and RPH have access to the NSW Clinical Excellence Last Days of Life Toolkit that is compliant with the National consensus statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
Best practice guidelines for the prevention of pressure injuries are used to screen all patients on admission and daily for at risk patients. Guidelines for the management of pressure injury management and wound care is available. Strategies are in place for the prevention of pressure injury. Audits demonstrate no pressure injuries above stage one treated within the last two years. These actions ensure compliance with NSQHS Fact Sheet 'Identifying Key Actions to prevent pressure injuries and wound management.'	
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	
A skin integrity inspection is conducted within eight hours of admission and daily thereafter in accordance with policy. The initial inspection is recorded on the comprehensive care plan and on the daily care plan from Day 2. Audits of the charts indicate that the compliance with this is high	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is available to patients, their carers / families covering pressure injury prevention. This information is in a user-friendly format and staff were able to describe how they would use it. Pressure-relieving devices are available in inpatient areas and operating theatres, and the introduction of new mattresses has reduced the risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. post-fall management	
Comments	
The Falls Risk Assessment Tool (FRAT) is utilised to assess falls risk. Several strategies are used to manage falls including, maintaining functioning walking aids and wheelchairs, adjusting chair heights, appropriate footwear, observing in a room that is closer to the nurses' station, calls bells in reach, always escorting to the bathroom if required. Patients at high risk of falls may be specialled either by a member of staff or family. With consent the use of a baby monitor has been trialled to prevent falls. Falls alerts are documented on the care boards and on stickers within the clinical notes. Following a rise in falls in 2022 falls stickers in the notes were initiated as were pose fall huddles to review processes. This has resulted in a reduction of falls to below the industry rate. Rehabilitation is provided for patients as needed following falls. Incident data related to falls is analysed and reported through the organisation's governance structure.	
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	
Equipment, devices, and strategies to prevent falls and minimise harm from falls are available to staff with most of RPH beds now high low beds and used appropriately for falls risk patients. Members of the assessment team saw evidence of the use of these in accordance with the requirements of individual patients as identified on screening.	
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	
Falls prevention information is contained in the Safety During your Stay brochure and re-enforced with Falls Prevention brochure for both the hospital and home situation which is provided to patients and families together with discussion relating to falls prevention. There is also information regarding falls provided on the website. This information is in a user-friendly format and has been scrutinised by the Consumer group to ensure literacy appropriateness.	
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	
Malnutrition screening occurs for all patients on admission with referral to a dietitian as required. Meals are supplied from a dedicated kitchen that is audited annually by the local council. The kitchen while small has a sustained 'A' grade rating monitoring hygiene, food storage practices, equipment maintenance, training, and environmental service standards.	
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	
Meals are freshly prepared and approved by a dietitian. Referral to dietetics and speech pathology are available as required. Patients requiring texture modified diets are provided with information and education. Total Parenteral Nutrition (TPN) is available oncology patients where required. Meals are served do not require assistance to open packaging, but assistance is available with feeding should this be required.	
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	
All patients have a Cognitive Impairment Risk (CIRAT) on admission and as required throughout a patient's admission where clinically indicated. If there are more than two risk factors identified, the 4AT risk assessment for delirium is conducted. Patients who are identified also have an alert sheet completed. Evidence based policies and procedures support staff in developing appropriate management / care plans and these strategies are reviewed for effectiveness. Screening is based on the National Consensus 'Elements for Recognising and responding to acute physiological deterioration' (Third Edition). Screening rates are audited and reported through the organisation's governance structure. The organisation is compliant with the requirements of Advisory 18/12 (1.27b), AS/2201 and ACSQHC Fact Sheet 11(5.29a). Anti-psychotics and psychotropic drugs are stored according to legislation. It is rare to use chemical restraint for patients with delirium or cognitive impairment, however if this is required family are consulted and patients may be transferred to more appropriate facilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Comments	
Documentation reviewed by the assessment team members demonstrated that systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken and compliance with screening is reported at 95%. Staff were able to describe how they collaborate with patients, carers, and families in caring for patients with cognitive impairment. This screening process is in accordance with the National Consensus: Essential Elements for recognising and responding to acute physiological deterioration (Third edition). The RPH uses the sunflower, which is completed with the family to identify triggers and to provide information regarding the patient likes and dislikes. To identify triggers and possible solutions to reduce agitation. Families are encouraged to partake in the patients care where this is their wish. A cognitive impairment information brochure is provided to the patient and their family. Care of patients with cognitive impairment and delirium are referenced by the Delirium clinical care standard.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Strategies and screening tools are in place to identify patients at risk of self-harm and / or suicide. On identification of patients who may be at risk there are documented intervention strategies and an alert sheet completed and an alert on webPAS. Where patients are identified as at risk there is access to psychiatrists if required and monitoring for the patient.	
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	
Strategies and screening tools are in place to identify patients at risk of self-harm and / or suicide. On identification of patients who may be at risk there are documented intervention strategies identified. Where patients are identified as at risk, there is access to referral services through the local Mental Health Teams. If acute deterioration of a patient's mental state should occur policies and procedures are in place for transfer to an appropriate facility.	
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	
All staff undertake Workplace Aggression and Violence Education (WAVE) with 93% completion. A process of using of family experience and/or intervention aids in calming and de-escalating situations is in place.	
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	
RPH has a risk assessment on admission to identify patients who may have a mental health history or dependencies that may lead to violence and aggression. The processes to manage aggression aim to effectively minimise harm to patients, carers, families, staff, and visitors with duress alarms available throughout the hospital. Incident of aggression are reported through the risk management process and governance structure. Alternate therapies are offered where indicated. An emergency code black response procedure is included in induction, and should a patient become aggressive or violent the staff enact the Code Black Emergency Policy.	
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	
RPH has a restrictive practices policy in place for restraint where clinically indicated with mitigating strategies in place to reduce the use. All episodes of restraint are documented in RiskMan, reviewed, and reported through the governance structure.	
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		
There are no mental health beds at RPH, and seclusion is not practiced and therefore this should be rated as N/A.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
NA	All	**NA Comment:** Non gazetted service does not use seclusion. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Governance, policies, procedures, and reporting are all well established locally and nationally. There is evidence at RPH of systems in place to ensure timely, effective communication that supports continuing, coordinated, and safe patient care. These systems are supported by executive leadership and a culture of patient-centred care. Communication for patient safety is well embedded in the clinical governance framework and there is a maturing culture of patient participation in care with evidence that the patient is at the centre of care. The Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication. There is evidence that systems and strategies are in place to ensure that communication for patient safety is integrated and is used to inform changes and future directions. RPH has good relationships with its VMOs. Evidence of these relationships were seen by the assessment team.	
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	
Strategies are in place across the organisation to clearly identify patients, communication of information both routine and critical for both patients and staff so ensuring continuity of care, sharing of information and patient safety including follow up phone calls following discharge. There are systems in place to monitor effectiveness of communication for patient safety. This includes audits of patient records, patient surveys, complaints management and audit of clinical handover. These are reported via the Quality Committee to the Executive. The risk register includes matters relating to communication such as consumer feedback, clinical handover, and discharge planning. This feedback drives improvements and changes in communication strategies and processes. There is no evidence of adverse outcomes relating to communication following surgery or discharge instructions.	
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	
Examples of involvement in communication for patient safety were witnessed during the assessment and well done with constant patient involvement. Care being given at the bedside, bedside handover, multidisciplinary meetings held weekly, and family care planning meetings scheduled, as necessary. A review of a sample of hospital records found clear, accurate, detailed records that assist both the provision of and transfer of care between clinicians and care areas. The Quality Action Plan reinforces teamwork to identify areas for improvement. It encourages patient participation in goal setting and other aspects of their care which was evident during assessment. Clinicians described good working relationships and communication with VMOs. There is a determined intent to enable patients to be involved in communication of their goals of care during bedside handover. During survey, the assessors observed this, and patients were well prepared and had their questions ready for the clinicians. There is an extensive range of information available to support and inform patients and families during their episode of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes guide the use of appropriate identifiers in procedure matching, transfer of care, handover, discharge and where changes in clinical care / patient risk profile are identified. Documentation reviewed by the members of the assessment team supported the use of specified identifiers in all situations. The Patient Finder, a guide assisting families and friends to track the status and location of a patient, together with clear directional signage throughout the hospital are all effective ways to communicate with patients, families, and the wider community. The invaluable role of a Concierge at the hospital entrance assisting with Covid requirements has not been continues but was extremely useful during the Covid episode. There is information and signage identifying discharge time which has caused some anxiety for patients and families in the past, but discussion with staff ensures appropriate discharge times especially for out-of-area patients. The National PACU transfer, or discharge assessment document provides clear criteria for patient transfer and is fully utilised and liked by staff. Follow up phone calls to day surgery patients re-enforces ongoing care needs and processes.	
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	
During the assessment, many checkpoints confirm patient identification utilising approved identifiers were observed by the assessment team. Identity was checked at admission, bedside handover, any transfer to and from wards, on reception to and from theatre or clinical departments. Patients were also able to describe the questions asked to confirm their identity and the Assessors witnessed this. All clinical staff attending the patient confirmed their identity, with non-clinical staff addressing patients by name. Strategies are in place for daily photos of potentially absconding patients to easily identify them through their face and clothing.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.06	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
The Assessors noted the use of approved patient identifiers as noted in Action 6.5. Time out and procedure matching in theatre and departments also included patient identification. Monitoring, auditing, and reporting of ID matching is in place and there is no evidence of any adverse outcomes. Food service staff have procedures for patient identification at meal delivery including talking to the patient and checking the bedside whiteboard.	
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
Standardised handover sheets are used by clinical staff to ensure the handover of all appropriate, critical information, identified risks and patient needs. There is a systematic approach to handover using the ISBAR framework with evidence of bedside handover with patient participation. Bedside handover enables the staff and patient to reinforce goals of care and patient progress as well as discharge planning. Where observed, the patients seemed to really appreciate bedside handover and used it as an opportunity to ask questions. Staff could explain their respective roles in clinical handover the processes used to support this including the minimum information communicated at clinical handover. This supported the clinical handovers witnessed by members of the assessment team. Compliance audits of bedside handover identify 100% compliance, and this was observed during assessment.

Rating	Applicable HSF IDs
Met	All

ACTION 6.08
Clinicians use structured clinical handover processes that include a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
The assessors attended both shift and transfer handovers in clinical areas as well as time out in theatre. The intent of handing over responsibility and accountability for care was evident. Monitoring of clinical handover occurs with high compliance; this is reported up to the Quality and Risk Management Committee and Executive. There has been no negative feedback from patients about their participation in handover and no evidence of privacy breaches.

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	
Clinical communication processes are in place to ensure the timely reporting of risks and alerts to ensure clinicians can make care decisions and in accordance with patient and family wishes. A multidisciplinary handover was not observed during the assessment, however there are good processes for referral and review across the treating team. The use of track and trigger charts provide clear guidance for staff in identifying critical information for reporting, together with new information gathered from patients or family which impacts of patient care and safety. Processes are in place for staff to contact VMOs should this be necessary and clear lines of communication for escalating information within RPH are in place and known by staff. Critical information is also transferred during ward handover.	
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	
RPH has a policy and process for the escalation of care and critical information by patients and families. This allows the patients or family to escalate clinical concerns or questions about care. Information is given to patients on admission. While the intent of the system is good, several patients spoken to identified they had not needed to use it, with others apparently with little knowledge of this process. Staff also indicated they had not received any concerns or questions. The introduction of back to the bedside nursing and contemporaneous documentation are good initiatives which may be the reason escalation of care communication has not been needed. Currently notices outlining REACH are small and contained on the Patient care board the initiative to provide larger notices alongside the care boards and further promotion may see more use of the process.	
Suggestion(s) for Improvement	
Progress the new posters and Strategies to ensure all patients and families are aware of the escalation process and how to activate this.	
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	
Policies and processes are in place guiding the documenting of patient information at RPH where a paper medical record document system is used. Regular medical record audits are conducted as per the audit schedule and demonstrate high compliance with all aspects of documentation and storage. Patient's clinical notes are available to all clinicians at the bedside enclosed in drop down boxes for privacy and to provide a documenting area, again taking care back to the bedside. Records seen during assessment were contemporaneous with all medical professionals utilising the same notes and assessments with specific entries such as Pharmacy or Physiotherapy clearly flagged. Discharge summaries from both the emergency department and wards are faxed to GP surgeries with 98% sent within 48-hr of discharge. Patient admissions and registration areas were visited with Medical Record Departments having restricted access. Systems are in place for secondary storage and archiving. Medical records are delivered to clinical areas as requested by courier service which maintain privacy and accurate and speedy transfer. While some patient admission and risk information is available electronically through the whiteboards, there is no evidence of systems in place as yet for an electronic health record.	
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	
Assessors confirmed that RPH has policies and procedures in place to guide all aspects of blood management. There is a Blood Management Working Party which monitors all matters related to blood usage. This reports to the Quality and Risk Management Committee as part of the RPH governance structure. Blood safe training is one of the mandatory training programs at RPH and data presented indicated a completion rate of this training was 94% at the time of assessment.	
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	
RPH monitors blood management processes including adherence to policy, completion of consent, blood wastage and indications for transfusion. The wastage of whole blood was 1.06% in 2022 and this represented one unit which was accidentally left out of the blood fridge and needed to be discarded. Indications for transfusion are that it is not to be given if Hb is greater than 100g/L. Assessors reviewed RPH reports which indicated no instances where this guide was breached in the past 12 months.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
RPH supports the engagement of consumers in care related to blood management including informed decision making. Assessors observed a blood transfusion procedure while on site and spoke with the patient involved. The patient confirmed the information she had been provided with and that her questions were answered prior to consent being obtained. This process was supported by the regular checks with the patient and cross referencing of all identifying information prior to the commencement of the transfusion.	
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	
RPH has processes and policies which support the clinically effective and efficient use of blood and blood products. Utilisation rates and wastage are monitored. All blood transfusions are planned as no emergency transfusions are given at RPH.	
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	
Assessors reviewed a limited number of transfusion records including one as it was being completed at the bedside during a transfusion procedure. It was apparent that there was effective documentation of decision making and transfusion details. RPH undertakes a regular transfusion pathway audit as part of its audit schedule.	
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	
RPH has policies and procedures in place which are based on and consistent with the national guidelines and national criteria for the prescription and administration of blood and blood products.	
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	
RPH has policies and processes are in place to support reporting of adverse events related to transfusions. These are monitored and reported via the incident reporting system in the first instance and through to the Blood Management Working Party. No incidents have been reported.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Assessors confirmed that RPH has a process in place to contribute to haemovigilance activities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard, or transfer	
Comments	
RPH has a blood fridge on site and blood and blood products are stored, distributed, and managed in compliance with legislative and regulatory requirements. Assessors viewed the blood products register and it was evident that all products were able to be traced. Processes are monitored and reported through the Blood Management Working Party. Any incidents related to inappropriate handling of blood or blood products is reported and managed through the incident management system.	
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	
Blood can be ,administered in emergency situations at RPH however to date this has not been required. All procedures are planned and therefore effective processes are in place to manage the availability of blood and blood products, eliminate wastage and respond to shortages. Availability and all usage are monitored.	
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	
RPH has policies, procedures and documentation are in place for the recognition and response recognition to acute deterioration. Training and education are advanced and consistent with both clear outcomes and competency measures in place, with staff able to describe their role in the event such a situation presented.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
The recognition and response systems are sound, effective with outcomes reported on in a consistent manner. RPH submits data on all MET calls into the RiskMan system these are investigated and reported on with the Quality manager providing a monthly report to the Clinical Management Committee. Audit results are reported to National Healthscope as a component of the KPI reporting tool.	
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	
Clinicians actively involve patients in their own care and have a focus on inclusion and shared decision making at all times ensuring that the patient is able to comprehend the information being shared. This process includes involving patients in open discussions, meeting their information needs and shared decision making in treatment plans. Staff engage with consumers through patient education both on commencement of care, at regular reviews and handovers. Escalation of care information is on all care boards for patients and family to escalate the need for care. The Qualtrics patient experience survey provides RPH with data on patient's involvement in clinical decision making. RPH have a developed consumer partnership plan 2021-2023.	
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	
RPH processes allow clinicians to detect acute physiological deterioration by accurate documentation and the monitoring of vital signs using trigger charts for adults and age-related charts for children. Individual patients are monitored by their own monitoring plan formulated, reviewed, and changed as required. The development of an acute Hyperthermia trolley in theatre with education and clear identification of staff rolls and while not yet had to be used is a good initiative.	
Suggestion(s) for Improvement	
Insert questions to the proposed online education to ensure staff completion and knowledge.	
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 national including the risk of delirium. All patients are subject to close monitoring and if a patient's observed mental state is deteriorating or delirium is identified an intervention is actioned. This is determined by observation and documentation that the patient's clinical presentation has changed and/or deteriorating and includes changes in both physiological measurements and abnormal observations and includes behaviour, cognitive function, perception, and emotional states. Processes are in place to support timely communication between members of the treating team and the patient, carers, and family members. The interventions are actioned in consultation with the treating team with rapid transfer to appropriate facilities clearly outlined. 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
Policies, protocols, and clinical documents identify and include triggers for escalating care including vital sign, pain, distress, and clear parameters for initiating a MET call. These are available for adults and age related for children. RPH have well embedded criteria utilising track and trigger charts to identify and progress the care of deteriorating patients. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. The requirements of Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs

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	
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers, or families to directly escalate care	
Comments	
RPH has processes are in place for patients, carers, or families to directly escalate care with information on the patient care boards at each bedside to ensure clear communication between all participants on patient care. The REACH procedure and process of escalating care clearly explaining to patients, carers, and families on admission. The current information is currently small and on the patient care board and following a review identified awareness as a hurdle to the use of REACH. A project is currently underway involving staff and consumers to design larger posters and a brochure which together with further education should ensure patients and families are fully aware of the 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	
RPH has policies and processes in place to escalate care and/or initiate any emergency response. Clinicians are well trained with medical management plans and policies in place these are developed and reviewed in consultation with the Communicating for Safety working party and tested in consultation with relevant clinicians. Equipment and emergency trolleys are standardised, are positioned, and available to meet the hospital's needs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
The staff use the RPH recognition and response systems that are in place in which clinicians are trained to use in an escalation of care. Clinicians have ongoing training at RPH with Advanced Life Support staff available on all shifts to ensure they provide the correct response to all medical emergencies.	
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. Timely response of MET Teams is measured and reviewed after every MET team response of Advanced Life Support (ALS) trained clinicians. All MET calls are entered into RiskMan and are subject to investigation and report to the Standard 8 Committee-Working party for continuing review and shared learning. While medical staff are not on the premises constantly evidence provide identified that RPH targeted those working in high-risk areas with 73% of medical staff presenting evidence of competency at the time of assessment.	
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	
In the event advanced care is required for any patient it is delivered by ALS staff who provide 24-hour cover. Policies and procedures are in place for rapid referral and transfer to an appropriate facility. PIPER utilised should paediatric transfer be required. Strategically placed emergency trolleys are located within the hospital and routinely checked.	
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	
RPH has policies and processes in place for the timely referral and transfer to mental health services to ensure that these referrals can meet the needs of patients whose mental status has acutely deteriorated. 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 rapid referral to appropriate care for patients who physically deteriorate. Staff were able to explain these processes to members of the Assessment Team and the effectiveness of escalation of care processes are monitored.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Standard 6

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 1019.6.04** Review, develop and document a Post Anesthetic Care Unit (PACU) discharge criteria for patient discharge to the wards and day procedure unit. **Risk Rating:** Low

Organisation Action taken	**Assessor's Response**
Finalisation of PACU form HMR9.50 Post Anesthetic Care Unit Report by national perioperative committee- National form implemented Nov 2019. Contains discharge criteria and score. Forms part of handover to ward or Erskine Audit of completion of the discharge checklist is 100% **Completion Due By:** 31/12/2019 **Responsibility:** Jodie Bennetts **Organisation Completed:** Yes	**Recommendation Closed:** Yes Evidence presented at assessment ensured that this recommendation could be closed.

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 1019.6.11** RPH review best practice medical record documentation to ensure accurate statements of clinical interactions between the patient and treating doctor relate to assessment and diagnosis, care planning and treatment. Be sufficiently clear, structured, and detailed to enable other members of the health care team to assume care of the patient to provide ongoing care at any time. **Risk Rating:** Low

Organisation Action taken	Assessor's Response
Drop down boxes have been installed in wards. Lockable to ensure privacy requirements are met. Medical record contains integrated progress notes with all clinicians documenting in same progress notes and have access to all documentation for current admission in bedside folders at point of care. Review of compiling of medical record- ensure flow and ease of location of documentation and standardisation between departments-Medical Records compiling is now standardised between all departments. Decluttering and removal of dividers etc not in use and reorder of documentation to ensure flow for staff use. Secondary review in 2023 change to medical record- removal of pathology and radiology dividers and pathology and radiology now filed at the back of the relevant admission. Review of filing of correspondence, was all together at front of record. Correspondence is now filed at the relevant admission. Dividers for folders at point of care- clear and durable folders at point of care to ensure standardisation across departments and ease of location of care plan and documentation for continuity of care-dividers colour coded and labelled to ensure staff can locate required documentation with ease. Feedback from staff and VMO's is positive in terms of use. Move to terminal digit filing system in health information department.	**Recommendation Closed:** Yes Evidence provided at assessment enabled this recommendation to be closed.

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Documentation audits conducted in 2020 and 2022. Documentation audit completed with revised template in Dec 2022. Overall compliance for all 93%, Day Oncology 87% overall compliance- increase of 10%, Medical overall compliance 92%-drop 3%, Surgical overall compliance 98%- increase 3%, Day Procedure overall compliance 95%, increase 4%. Compliance with medical documentation- 92% Compliance with nursing entries-99% Compliance with allied health entries-100% Compliance with medical record standards-97.75% Staff education and training in documentation, medical terminology, legal note writing, communication, and documentation. Comprehensive Care audit introduced in 2023 overall compliance 87% May and reaudit July 92% **Completion Due By:** Oct 23 **Responsibility:** Jodie Bennetts **Organisation Completed:** Yes		

Standard 8

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 1019.8.10** The BLS/CPR training status of the Medical Officers to be recorded by RPH according to the Commissions Advisory relating to this. **Risk Rating: Low**

Organisation Action taken	**Assessor's Response**
Clarification from head office on Healthscope legal requirements for training of VMO's-Advice and assistance with gap analysis review against the fact sheet. Training requirements only for employed doctors and monitoring for VMO's via observation and audits. Risk registers update-Risk 19225 action on risk register-Gap analysis completed with National support and guidance, risk updated to reflect. Conducted gap analysis using Healthscope template on training requirements for VMO's-gap analysis is completed and in accordance with the Training requirements for credentialed practitioners released by the ACSQHC in 2019, Ringwood has no employed doctors, monitoring is required, and training opportunities shared with credentialed practitioners. Letter to doctors around fact sheet on clinician training-sent out to doctors with links to hand hygiene, ANTT training and also calendar of dates for BLS competency assessments onsite. Training and assessment dates provided to VMO's and displayed in key areas. Declaration of training completion by VMO'- sent out via survey monkey. Identification of risk for doctor compliance with training requirements-risk matrix developed, no high-risk areas. VMO's at Ringwood do not form part of the rapid response team and are therefore not considered a high risk for BLS competency.	**Recommendation Closed:** Yes Evidence presented at assessment enabled this recommendation to be closed.

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Staged declaration of VMO completion of training action plan in place. Healthscope policies in draft to support requirement for VMO training and/or declaration. **Completion Due By:** oct 23 **Responsibility:** Georgia Banks **Organisation Completed:** Yes		