National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Final Report

The Hills Private Hospital

BAULKHAM HILLS, NSW

Organisation Code: 125984
Health Service Facility ID: 101031
ABN: 85 006 405 152
Assessment Date: 27 – 28 August 2024

Accreditation Cycle:

Contents

Introduction

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

ACHS is approved to accredit the following standards

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

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

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

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

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

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

The Commission works in four priority areas:

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

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

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

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

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Carol Martin	Yes
Lead Assessor	Jean Evans	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Hills Private Hospital, The. The accreditation decision was made on 02/10/2024 and Hills Private Hospital, The was notified on 02/10/2024.

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

The Hills Private Hospital underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 27/08/2024 to 28/08/2024. The NS2.1 Short Notice Assessment required two assessors for a period of two days. The Hills Private Hospital is a private health service and was last assessed between 2/11/2021 and 4/11/2021.

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

The Hills Private Hospital (THPH) is a 111-bed Rehabilitation and Mental Health Services facility located in Baulkham Hills, about 30 kilometres from the Sydney CBD. THPH underwent a Short Notice Assessment against the National Safety and Quality Health Service (NSQHS) Standards (second edition) from the 27 – 28 August 2024. The assessment involved two assessors. Approximately 75% of the assessor's time was spent in operational areas during the assessment, enabling interviews to be held with staff, patients and relatives.

THPH is led by a dynamic executive and management team focused on the highest safety and quality outcomes for both patients and staff. The assessment went very smoothly with all staff participating enthusiastically demonstrating knowledge of the services being provided, their patients and responsibilities. There have been changes in senior positions in the organisation during the last 18 months, but there are close cohesive relationships that have been formed across the organisation, with all working as one team respectful of each other, to provide safe and high-quality care for patients. This was evidenced throughout the THPH.

There were two recommendations to address from the previous assessment: Actions 1.22 and 1.23. Sufficient evidence was made available to close the two recommendations.

THPH is compliant with all Advisories and Clinical Care Standards relevant to the organisation, and as published by the Australian Commission on Safety & Quality in Healthcare.

As part of the Commission's requirements, a high-risk scenario was undertaken by the assessors. This was undertaken using the PICMORs methodology and consisted of discussion relating to the large number of incidents of falls. This was addressed in a most comprehensive manner, supporting the organisations ability to mitigate the risks.

The Hills Private Hospital 2024-2025 Clinical Governance Plan that is essentially part of the One HealthScope 2025 strategy, provides the framework and direction that support the processes for the management of risk and continuous quality improvement.

The workforce presented as a cohesive team who all contribute to the delivery of safe, high quality and comprehensive care. The daily Bed Management meetings, which in addition to patient management incorporated discussion regarding staff planning and safety management items, demonstrated the effectiveness of face-to-face communications and ensured that all key members of the clinical and non-clinical teams (e.g. domestic services) were aware of the day's essential hospital activities.

The Healthscope framework of policies and procedures, processes for the reporting and management of incident and risks, complimented by the eQuaMS Quality Management systems, the MARS audit platform and the DASH real time data analytics real time reporting tool, provides the ability for staff to have all of the necessary patient-related information available at all times.

A comprehensive framework of policies and procedures support consumer engagement. The practice where two Consumer Consultants attend the hospital weekly, and meet with patients, provides powerful feedback and information to THPH that hospital staff are able to use in order to benefit the care of patients, improve service delivery and avoid formal complaints, through patient concerns being listened to.

The regular weekly Patient Forum led by a staff member and attended by the assessors, demonstrated the interest by patients in their attendance of the coffee and cake session. This opportunity was used to discuss the meaning of the REACH process, as well as inviting feedback on "What is working well", "How could we improve?" and "Would you recommend our services to others?". This is a unique way of determining where quality improvements may be made, and how patients may be treated well and cared for effectively.

Infection Control is part of everyday practice that aims to improve outcomes and promote a zero acceptance of avoidable healthcare associated infections.

There is an established infection control framework to prevent and control the spread of infection that is supported by policies and education. Cleaning schedules are in use and reviewed with appropriate action items. Infection control is part for the mandatory training for staff.

Assessors noted strong evidence of governance and monitoring for safety related to medication management. Patient experience survey results reflect high consumer satisfaction with the medication information provided. Results of audits confirm compliance with medication policy related to reconciliation and medication plans. Medication charts are checked at the change of each nursing shift. Assessors confirmed safe practices are in place of the secure storage and distribution of medications.

There is an antimicrobial Stewardship System in place underpinned by policy and procedures and managed via the Infection Prevention & Control (IPC) committee.

Documentation demonstrated that processes are in place for implementing policies, managing risks and identifying training required to deliver comprehensive care.

Members of the multi-disciplinary team were able to describe how THPH safety and quality systems are used to achieve this. A review of clinical documentation confirmed that processes are in place for managing risks associated with comprehensive care.

There is appropriate training for staff on identifying Aboriginal and Torres Strait Islander patients and staff routinely ask the question and understood the importance of recording information in administrative and clinical information.

Goals of care for patients are articulated in the clinical record and established in partnership with patients, their carers and families. The planned goals are reviewed regularly, and changes documented in the medical record.

There is a raft of evidence that demonstrate THPH has systems in place to provide effective communication and documentation to support continuous and coordinated safe care for their patients. Staff focus on supporting the development of individual goals for recovery and support the development of skills that enable a patient to achieve those goals.

There is a patient-centred approach to clinical handover. Staff use the ISOBAR format at the daily bedside handover and clinical handover between each shift.

Patient care boards in each unit reflect current patient care and alerts are highlighted.
Patient identification and procedure matching are well understood and given appropriate attention by all staff.

The committee structure, systems and processes for the management of blood transfusions were comprehensive and robust. Although there is a low number (10-12) of blood transfusions that occur annually, the staff education, competencies and preparation for Blood Transfusions were impressive.

Training of staff to recognise and respond to physical and mental state deterioration is a priority for THPH, and compliance rates are high. The display of the REACH information in each patient room is a reminder to patients and their visitors, to recognise clinical deterioration and how to report it. The Patient Forum focus and discussion around the meaning of REACH for acute deterioration, further emphasised the importance of recognising and reporting a patient's deterioration.

Advance Care Directives are discussed with patients on admission, and this is documented in the medical record. THPH shows great empathy should patients decide to palliate at the hospital, with special arrangements being made and accommodation provided that allows relatives to be with their loved one.

All actions contained in each of the standards were assessed as Met. At the time of the assessment, opportunities for improvement were suggested to the hospital for their consideration and are included in this report as suggestions.

Summary of Results

The Hills 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

Hills Private Hospital, The

Site	HSFID	Address	Visited	Mode
The Hills Private Hospital	101031	499 Windsor Rd BAULKHAM HILLS NSW 2153 Australia	Yes	On Site

Shared and Contracted Services

A sample of Contracts / Shared Services have been verified.
The following shared services are used by The Hills Private Hospital.

Provider	Description of Services	Verified During Assessment
Westview	Patient Entertainment - TV	Yes

The following contracted services are used by The Hills Private Hospital.

Provider	Description of Services	Verified During Assessment
BGIS	Air Conditioning Filters	Yes
BGIS	Air Conditioning Plant & Equipment	Yes
FORM One and BGIS	Fire Equipment, Prevention and Alert Systems	Yes
ADT	Fire Monitoring Alert System	Yes
BGIS (Stokes and AESC	Fire Certificates & Asbestos Report	Yes
Pelican Refrigeration	Cool room/freezer maintenance	Yes
SC Medical	Test & Tag (Non-medical)	Yes
Kleenduct	Kitchen Exhaust cleaning	Yes
BGIS	Generator Servicing	Yes
BGIS	Emergency Light Testing	Yes
Integra	Water treatment/cooling tower servicing & cleaning	Yes
CleanAway	Grease pit pump out	Yes
BGIS	Grease pit Maintenance	Yes
Rentokil	Pest Inspection & Treatment	Yes
Dishtek/Hobart	Oven & Dishwasher Servicing	Yes
Pelican Refrigeration	Ice Machine Maintenance	Yes
BGIS	TMV Certification	Yes
BGIS	Steam Boilers	Yes
HICMR	Infection Control Consultation Level 2	Yes
CORE GAS	Air/Oxygen Outlets and containers	Yes
Malones	Sanitisers & Washers	Yes
Automated Parking Systems	Carpark ticket machine & Boom Gates	Yes
Roejen	Pool plant/disinfection/filters & maintenance	Yes
SC Medical	Test & Tag / repair medical equipment	Yes
BGIS	Nurse Call System	Yes
CleanAway	Waste - General & Clinical	Yes
HPS Pharmacy	Pharmacy	Yes

Provider	Description of Services	Verified During Assessment
IT	Telephone/PABX	Yes
OTIS	All Lifts	Yes
BGIS	Electrical Maintenance	Yes
BGIS	Plumbing	Yes
High Land Security	Security Services	Yes
Independent Lock Smith	Locksmith	Yes
SC Medical	Bed Repairs	Yes
BGIS	Generator - Emergency Power	Yes
Australian Clinical Lab	Pathology	Yes

The Hills 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	
A review of the available documentation, consistent with the requirements of the ACSQHC Checklist for Assessors – reviewing information accessed and actioned by the Governing Body, supported by observations and interviews with key clinical governance leaders across the organisation, demonstrated that a culture of safety and quality improvement had been established. This was reinforced by the leadership team who set the organisation's strategic direction and ensured it is clearly communicated. The Hills Private Hospital (THPH) Clinical Governance Plan for 2024-2025 describes the governance related roles and responsibilities across the services and supports staff to effectively partner with patients and families. A Committee Structure has been established to monitor the effectiveness of the clinical quality system through audit, data analysis and incident reports. A risk management approach underpins all aspects of clinical safety and quality.	
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	
Executive staff and clinicians at THPH were able to describe how the specific health needs of Aboriginal and Torres Strait Islander people are being addressed. There is a low percentage of Aboriginal and Torres Strait islander people who are treated at THPH. Documentation reviewed by the assessors supported that the organisation has prioritised such health needs, and specifically on areas of inequity in service provision and outcomes for Aboriginal and Torres Strait Islander people. There was reference to Aboriginal and Torres Strait Islander events to be held mentioned in the organisation's regular Newsletter. REACH posters and patient brochures for Blood Safety management had incorporated special reference to Aboriginal and Torres Strait Islander specialised needs in their documentation. The organisation meets the requirements of Advisory AS18/04.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
Healthscope hospitals use a standardised format as part of the Clinical Governance Framework, and all staff in key clinical government leadership roles were able to describe the elements of the framework. This emphasises that the accountability for safe and effective patient-centred care is the responsibility of all staff. Senior managers were able to demonstrate to the assessment team how the Framework is used, and how the effectiveness is monitored and reported, with changes made where indicated.	
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	
Interviews with staff and managers were supported by observations and documentary evidence confirming that the organisation has strategies in place to monitor the effectiveness of quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people, on the rare occasions when THPH has a patient who declares that they are of an Aboriginal and Torres Strait Islander culture. The staff compliance with Cultural Awareness training is high.	
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	
Documentation reviews including the committee minutes of the Executive Committee, the Quality & Risk Committee and other relevant committees, along with interviews with senior managers of the Hills Private Hospital, confirmed that issues of safety and quality are key factors in the organisation's business decision making. The Quality Improvements planned support the importance of the safety and quality of health care for patients is constantly a focus of discussion by the organisation.	
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 the documentation, reinforced by assessor observations and interviews with staff, verified that they work within the governance framework. Staff confirmed that they understood their clinical safety and quality responsibilities and were able to articulate how the organisation monitors, reports and evaluates performance. Attendance at a daily Bed Management meeting by the assessors which also includes safety elements for staff and patients, demonstrated the regular and open communications that occur between the hospital executive and ward staff, ensuring that all are across the quality and safety aspects of the provision of care. The change from holding virtual meetings to face-to-face, which have proven to be more effective, also supported the importance of clear and open communications that are occurring across the organisation.	
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	
There is an extensive and comprehensive list of policies and procedures available on the organisation's electronic Hint system. Documents reviewed, plus interviews with senior managers could demonstrate how policy documents, procedures and protocols are managed to ensure that they are current, comprehensive, effective, appropriately referenced and comply with legislation and regulations, along with State requirements. The Corporate platform, complimented by local THPH policies, procedures and guidelines, ensures that a risk management approach is taken when defining the scheduled revision of key documents. All policies checked by the assessors had been updated in accordance with their scheduled review dates.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems
Comments
The organisation has a defined quality management system that produces performance and outcome data. Staff confirmed that they received information on quality and safety performance and that it is actively managed with minutes of meetings at all levels throughout the organisation supporting this. Outcome data and information is used to drive improvements through the clinical governance structure and is made available to staff, consumer representatives, the community and other stakeholders who are engaged in performance evaluation. The introduction of the MARS electronic audit tool has facilitated easier auditing across the organisation. Audits that establish low levels of compliance, are re-scheduled until there is an acceptable level of compliance. The Quality and Safety Boards that are displayed throughout the hospital wards, display monthly statistics for: Patient Safety, Work Health and Safety, Education and Training, Infection Prevention and Control, Patient Experience and VMO Experience. The practice by Healthscope hospitals to establish opportunities for shared learnings from sentinel events, incidents, near misses, complaints and coronial findings, is another commendable example of the organisation's attempt to improve quality and safety for patients and staff.

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
Senior staff confirmed during interviews how the organisation manages the safety and quality system. Reports, including audit results, are provided to the Board and senior management, the workforce, consumers and to Healthscope Corporate. Reporting is undertaken through a range of appropriate mechanisms, and in formats that are appropriate to the intended audiences. The implementation of the eQuaMS system has provided a repository of up-to-date quality, safety and management information that is easily accessible by staff. Where relevant, the information reported is trended.

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
Management and staff explained how risks are identified and managed and how this is influenced by staff, patients and carers. Information from a broad range of sources informs the Executive and leadership teams to define and operationalise the risk management system. The system is reviewed and refined as needed to ensure it remains effective in managing both corporate and clinical risks. The risk management system (RiskMan) includes business continuity plans to support service delivery in the case of an emergency or disaster. Assessors saw evidence that the system is actively managed, evaluated and improved as needed. Risk management reports are provided regularly to the governing body, management and staff.

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
Documents reviewed, plus interviews with staff, confirmed that all staff are encouraged to report any incidents or "near misses" through the incident reporting system, RiskMan. Patients and carers reported that they felt empowered to raise concerns. Safety huddles discuss incidents such as a Fall, and action lists are developed to manage the fall, and in an attempt to avoid further falls occurring. The clinical governance team provides analysis and feedback to all staff and key committees on incident reporting and trends. Trend analysis of incidents drives quality improvement activities, which are reflected in the organisation's risk register. Information on the outcomes of incident investigations is reviewed at the individual incident and aggregate levels to ensure the system is functioning as intended and to inform improvements where indicated.

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
The organisation has established an open disclosure program and policies, which are consistent with the Australian Open Disclosure Framework. There is a Corporate Policy and Procedure for Open Disclosure, which document the Principles and Procedures for Open Disclosure. The organisation monitors how, why and when open disclosure occurs, and records of open disclosure were viewed by the assessors. Staff were able to articulate their role in the open disclosure process and felt supported in initiating and participating in open disclosure. There is a high level of compliance rate for the completion of the Open Disclosure eLearning Program.

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	
The Hills Private Hospital uses a variety of mechanisms to seek and respond to feedback from patients, carers, families and staff about the quality of care provided by the organisation. Initial feedback may be given verbally, providing the opportunity for staff to address any concerns. The organisation is commended for its approach to receiving feedback from the weekly Patient Forums that it arranges with all patients and volunteers who are invited to enjoy a coffee and cake meeting, with selected staff. The occasion is used to seek feedback from attendees for a range of questions asked. In addition to an opportunity to seek feedback on improvements which THPH may make, it is a way of avoiding formal complaints occurring. Feedback is analysed, trended, reported and used to inform quality improvement strategies.	
Suggestion(s) for Improvement	
THPH should consider using the Patient Forum to analyse and comment on feedback given – positive and negative.	
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	
Assessors were able to review the organisation's complaints management policy and processes. This demonstrated that an organisation-wide complaints management system was established, which supports patients, carers and the workforce to report complaints. Documentation shows that staff and consumers are appropriately involved in the review of complaints, which are resolved in a timely manner. The organisation's KPIs ensure that responses are provided within the agreed timeframes. Feedback is provided to the governing body, the workforce and consumers on the analysis of complaints and action is taken to inform improvements both in response to individual complaints and based on identified trends which also inform the risk register.	
Suggestion(s) for Improvement	
As noted in action 1.13, THPH should consider using the Patient Forum to analyse and comment on feedback given – positive and negative.	
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
Documents reviewed, plus interviews with senior staff and management confirmed that the organisation analyses the demographics of its patient population and the broader community to identify those patients who are at a higher risk of harm. This information is used to support decisions on service delivery and planning to identify how to best address their needs. Patients are assessed for higher risks of harm, and alerts are included in their medical records with other appropriate actions taken. Self-identification of Indigenous status is low with only 1.7% in 2023 identifying as Aboriginal or Torres Strait Islander people. Patient brochures are available in THPH for commonly used languages including Chinese, Hindi, Arabic and Filipino.

Rating	Applicable HSF IDs
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
The healthcare record is readily available to clinicians at the point of care and is organised in such a way as to support accurate, comprehensive, and timely documentation. A hybrid medical record is used with a paper record still maintained, but aspects of the record maintained electronically on WebPAS. This includes all consent forms, which was determined during the assessment and during a check of a selection of paper medical records. Clinicians were able to describe how they use the healthcare record to assessors, and records were also reviewed by members of the assessment team. Healthcare records are maintained securely and comply with privacy legislation. Regular clinical documentation audits are undertaken, and reports are provided to clinicians, departments, and key committees, with remedial activity documented where it was required.

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
Since all Healthscope hospitals use the WebPAS electronic Patient Administration System, compliance with Advisory 18/11 is managed at a corporate level. Paper records continue to be used at THPH with aspects of the record in electronic form on WebPAS. The discharge summary has been automated since the last assessment, and this is now transmitted to the GP. The record/folder for the patient while an inpatient in the hospital, is maintained in the patient's room. This is integrated with the main record when the patient is discharged. The record is stored securely in the Medical Records Department. 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 Corporate extract and transmit the relevant patient medical record information to My Health Record (MyHR), and the organisation is compliant with the Commission's Advisory on this requirement. 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	
The assessment team reviewed documentation that detailed the orientation provided to members of the governing body, staff, contractors, casual pool staff, students and volunteers. Training identified quality and safety roles and responsibilities, and contracts and position descriptions further supported this. Training records are maintained and were made available to the assessors, similarly a random review of contracts and personnel records by the assessment team confirmed the veracity of orientation.	
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	
Interviews with clinical leaders confirmed that processes are in place to ensure that clinicians are working within the defined and agreed scope of clinical practice. Clinicians' scope of practice is consistent with the role delineation of the organisation. It is reviewed in accordance with policies and when required to accommodate new and/or altered procedures, or technologies. All THPH staff are required to complete mandatory training modules which includes fire training, manual handling, hand hygiene, code of conduct and privacy. The organisation's compliance with completion of mandatory training was reported as 83.6%. Close monitoring of completion of training occurs by management, with action taken when departments fall below the required level of compliance.	
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	
A Healthscope Aboriginal and Torres Strait Islander Cultural Awareness program is part of the mandatory training by THPH staff. The program and training records were reviewed by assessors and current attendance rates are high.	
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 for all staff that identify staff training needs. Healthscope Corporate provide a template to facilitate this process, with guides on the internet given to assist managers in conducting performance reviews. Education plans and training needs analysis are conducted in response to these reviews. Performance review completion is audited, and current compliance rates are 100%. Staff can articulate the performance management system and their role in the process.	
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
Defining the scope of clinical practice is handled competently by the relevant THPH professional groups, guided by Healthscope Corporate policy and procedures consistent with National Standards. The process for defining scope is monitored locally and nationally, and regularly reviewed. Individual scope of practice is reviewed and revised in accordance with policies. THPH do not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable. The organisation has reviewed and improved its documentation regarding privileges which can be conducted at The Hills Private Hospital and granted to the medical staff, in conjunction with the Recommendation made during the last assessment.

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
The credentialing period at THPH which was previously for five years, was proposed to be changed to three years and this was reviewed and approved by the Medical Advisory Committee (MAC) during the period of the assessment, and as part of other modifications being made to the organisation's By-Laws. All professions, subject to professional registration requirements, are monitored and checked on the AHPRA database. The credentialing processes are monitored and regularly reviewed to ensure they remain robust. Recredentialling is undertaken according to the organisation's policies and procedures. THPH do not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.

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. These are defined in position descriptions for staff employed by the organisation and in contractual arrangements for the provision of nursing pool staff and locum staff. Orientation and onboarding include information for staff on these responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
Clinicians are provided with adequate supervision according to their designated roles and responsibilities and this is supported by position descriptions and the organisation structure. It was pleasing to hear of the close relationship that exists between the nursing and medical staff, with examples of shared-learnings and education that occurs between the professional groups. In addition to senior nursing staff being on site 24 hours a day, staff are able to call the CMO who is on-call after 6pm each day.	
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	
The organisation provides clinicians with access to a range of tools, best practice guidelines, care pathways and the clinical care standards to support their clinical practice. This includes the Australian Therapeutic Prescribing Guidelines. Healthscope Corporate also maintain a virtual library service, which is available to clinicians, with articles ordered where required. THPH do not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.	
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
Clinical variation is monitored by analysing comparative clinical outcomes data, both internal and external, and results are used to inform individual and aggregate performance, support clinicians in actively participating in clinical reviews and to inform changes needed to minimise unwarranted clinical variation. This is discussed at the MAC, which includes multi-disciplinary representation. Where clinical variation is identified a risk management approach is used to minimise harm from unwarranted variation. Assessors were able to verify these processes through interviews with staff during the assessment. Healthscope hospitals have a shared-learning approach that encourages discussion regarding clinical variation and learns from others of alternative methods of improving its effectiveness. THPH do not provide Colonoscopy surgery, and the requirements of Advisory 18/12 are therefore, Not Applicable.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Comments	
A review of safety and quality documentation substantiated staff interviews and observations by the assessment team that the preventative and reparative maintenance of buildings, plant, equipment, utilities, devices and other infrastructure is undertaken to ensure that they are fit for purpose. Safety of the environment is considered in service planning and design. The recently approved contract with SC Medical Biomedical Services for all medical equipment and devices, has provided benefits through improved accuracy of asset registers, preventative maintenance and asset replacement plans. The close relationship that has been informed with the BGIS support staff for buildings and infrastructure management, will assist in the management and maintenance of the services provided in the hospital buildings, some of which are aging.	
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	
The organisation has undertaken a review to identify areas in the mental health ward that have a high risk of unpredictable behaviours and has processes to ensure emerging risk areas can be appropriately identified. Strategies have been developed to ensure that people are treated in appropriate areas and risks associated with unpredictable behaviours are considered. Processes are in place to minimise the risk of harm to consumers and staff by unpredictable behaviours. THPH staff are required to complete the Management of aggression and use of de-escalation strategies training as part of mandatory training.	
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	
Directional signage internally and externally is clear and fit for purpose. The Consumer Consultants have reviewed THPH signage and have made suggestions for improvements, which have been acted on. Visitor guides and hospital maps are available on the internet. Staff at Reception are available to assist visitors entering the hospital. The assessment team were able to successfully navigate an unfamiliar environment.	
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	
The hospital has set visiting time arrangements in place, and these are explained on THPH internet site. However, there is flexibility for visitors for Palliative Care patients. Staff and patients reported satisfaction with the visiting arrangements.	
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	
THPH demonstrates a welcoming environment for people from all cultural backgrounds, including Aboriginal and Torres Strait Islander people. With such a diversity of cultures supported at the hospital, the hospital has tried to demonstrate that all are welcome. The staff in the Reception area of THPH are available and show that they are happy to help all who arrive at the hospital. Small Indigenous flags are displayed at the entrance of all departments and wards, and indigenous artwork is displayed throughout the hospital.	
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
Interviews with staff and patients together with a review of policies and procedures supporting partnering with consumers show that the principles of safety and quality are applied when these documents are developed. Consumers are engaged in policy development, implementation and training. They assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation. Training is provided to staff, which shows a high level of attendance.

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
A review of documentation and interviews with staff and consumers confirmed that the organisation aims to improve partnerships with consumers at all levels. The assessment team observed how these strategies are monitored and how the organisation reports to the Partnering with Consumers Committee, and subsequently to the Quality & Risk Committee. Assessors had an opportunity to attend a Patient Forum, which is scheduled weekly, and when all patients are invited to a coffee and cake morning tea. The session attended by approximately 20 patients, carers and volunteers, was led by the Patient Services Manager who used the opportunity to gain feedback from patients regarding the services provided by THPH, including where improvements could be made. It was a positive experience, as almost all feedback was complimentary, and demonstrated how well the organisation does in partnering with consumers. He also used the opportunity to advise patients on the purpose of REACH for clinical deterioration.

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	
Suggestion(s) for Improvement	
The organisation focuses at the weekly Patient Forums on addressing the need for further Consumer Consultants to participate on a part-time basis in tasks that will benefit patients and the organisation. This may be ideas and suggestions to improve a patient's journey, and/or reviewing potential menu changes, or even reviewing patient's rooms to determine ways of improving the look and feel for long-term patients.	
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	
A review of the health service demonstrated that the Charter of Rights is consistent with the Australian Charter of Healthcare Rights and is readily available throughout THPH wards and patient rooms. Action is taken to ensure that the Charter of Healthcare Rights can easily be accessed and is understood. Reminders of the importance of the Charter of Healthcare Rights is displayed on walls throughout the hospital.	
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	
There are policies associated with informed consent for financial, procedures and for blood transfusion, which are available on the Hint electronic tool. The consent policy and processes comply with legislation, and reference best practice. The WebPAS patient management system supports that there is compliance with the consent occurring. This is also audited on a regular basis. Interviews with staff indicated that they understood their responsibilities with respect to informed consent. The requirements of Advisory 18/10 have been met with respect to informed financial consent.	
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	
A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care, plus the process to be followed if a substitute or alternative decision-maker is required. Staff were able to articulate this process and their access to the relevant policy.	
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
Interviews with patients and clinicians confirmed that staff work with patients, or a substitute decision-maker in shared decision making about their care planning, and the development of goals of care, when and where it is appropriate. The regular updating, during clinical handover, of the Patient Care Boards in each patient's room is impressive. The modification of the Boards to make it possible for patients to be able to read the boards, has been a benefit that was suggested by THPH Consumer Consultants. Patient goals are also reviewed during therapy sessions that are facilitated by Allied Health staff.

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 and patients were able to describe to the assessors how patients are actively involved in their care. Patients and carers interviewed confirmed this, and satisfaction surveys undertaken by the organisation also support that patients are satisfied with the level of engagement in their care. Confirmation of this was also evident during the weekly Patient Forum, from the many complimentary feedback comments provided by patients and carers regarding staff. Observations by the assessment team during clinical handovers supported that patients generally like to be involved in care discussions and decisions.

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
A review of information provided to consumers through a wide range of mechanisms demonstrated that significant action has been undertaken to align communications with the needs of the patients, carers and their families. The diversity of the local community has been considered by the organisation and is a topic for discussion at the weekly Patient Forum. The differences in the diverse cultures are represented including their menu preferences. The documentation produced by the organisation has determined that the most common languages spoken and read are Chinese (Mandarin and Cantonese), Hindi and Arabic, in addition to English. The Blood Transfusion Packs are available in the most commonly used languages, and the patient information racks had brochures in the different languages. Translator services are available when required.

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
Documentation reviewed by the assessment team, and interviews with Consumer Consultants confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs. A Consumer Approved Publication Logo (CAP) displayed on the document confirms that it has been consumer reviewed and approved.
Suggestion(s) for Improvement
Take draft patient information including brochures to the Patient Forum for review.

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
Clinicians were able to articulate how they effectively partner with patients in their care whilst accessing services provided by the organisation, and how they work with patients to support their ongoing care needs. Observations by the assessment team during the bedside handovers reflected the benefits achieved from patients keen to be engaged. The current practice where two of the Consumer Consultants meet with patients every Wednesday, and discuss anything that is important to the patient, is one to be commended. It provides an opportunity for patients to ask questions of the Consumer Consultants, which may be taken to staff, and staff are able to provide the feedback which is taken back to the patient. It has been an opportunity to simplify an ongoing care or medication query. The attendance of patients and family members at case conferences and in care planning and goal setting, is also a beneficial approach to ensuring that the needs of the patient are addressed. Patient satisfaction with the information provided to them is reported as high as is their satisfaction with discharge planning. Patients who were interviewed by assessors also supported that they felt information was provided to them in a manner and format they could understand.

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	
Interviews with the Consumer Consultants confirmed their active roles in the governance and evaluation of health care across this organisation. In seeking feedback on service delivery, the organisation engages various mechanisms that encourage input from a diverse range of consumers and from the broader community. It also regularly seeks feedback from the volunteers of THPH and during the inpatient Patient Forums.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	
Documentation and interviews with Consumer Consultants confirmed that they felt supported in their roles. This includes orientation for Consumer Consultants and ongoing education where needed. Consumer Consultants reported being satisfied with the level of support provided to them and stated that the organisation was responsive to their information needs in interpreting survey results, data and documents.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
The organisation has pursued a range of activities to better partner with local Aboriginal and Torres Strait Islander communities, and to better understand and meet their specific and unique healthcare needs. Staff interviews and a review of documents confirmed that the organisation actively engages with Aboriginal and Torres Strait Islander communities and seeks their input into service planning and care.	
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 and managers were able to explain how the organisation works with consumers to incorporate their views and experiences into training and education for the workforce. The feedback provided during the one-on-one sessions that the Consumer Consultants hear during their weekly catchups with patients, is a most effective approach to learning from patients of their views and patient journey experiences. It helps to learn how the workforce may modify their approach, where applicable. The regular THPH newsletter is an effective communication that regularly occurs and provides an opportunity for staff to communicate healthcare information for patients, carers, families and for staff. Staff interviewed were also able to provide examples of this training. Training records and programs were sighted by the assessment team that support this occurring.	
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	
All the areas visited by the assessors at THPH were clean, well-organised, and free from clutter. It was obvious staff took pride in their workplace which was supported by environmental cleaning and an established auditing schedule. Infection control is part of annual mandatory training for staff which includes a training package on aseptic technique. Personal Protective Equipment (PPE) was available for staff and sharps containers were securely stored in the units and waste management strategies were evident. Any reusable devices or equipment are cleaned each time they are used. It was noted by the assessors that the patient washing machines located in all the units had signage instructions for cleaning after each use and wipes were made available for this purpose.	
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
A comprehensive physical assessment is conducted on all patients on admitted to THPH which includes infection control screening. Routine clinical observations are conducted daily. There are well established plans to manage public health and pandemic risks. Assessors were acquainted with changes to practice as the guidelines for response to Covid have changed and they sighted the stock of personal protective equipment which is available to enable expeditious response to an infectious outbreak.

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 an established infection control program that is supported by the appropriate expertise, policies and education. Infection control management is part of the Quality Improvement Plan and regular audits are conducted to monitor and evaluate compliance. All patients have a comprehensive medical review on admission that includes infection control screening.

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
Interviews during the assessment demonstrated that the workforce understands the process of partnering with consumers. There is information available to patients, family and carers on infection control throughout the clinic. Posters display hand washing techniques and the correct method to sneeze or cough. Whilst rates of infection in the patient population are low, minutes of the infection control meeting showed evidence of routine surveillance and actions taken in response to any identified infection.

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
There are processes in place to apply standard and transmission-based precautions consistent with relevant legislative, State, Professional and local policy requirements. Strategies include hand hygiene, personal protective equipment, cleaning and appropriate handling and disposal of sharps, all of which are the organisations' first-line approach to infection prevention and control. THPH surveillance program ensures data is collected, monitored and reported with appropriate actions and decision making to prevent healthcare-associated infections and also includes a comprehensive antimicrobial stewardship program.

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
Staff have access to the full range of Healthscope policies. The policies for IP&C are accessible to all staff via eQUAMS with processes in place to inform staff of any new or updated policies.

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
Staff have been trained in the use of personal protective equipment and practical assessment occurs of individual's capacity to demonstrate donning and doffing technique. 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. Staff were able to confirm their use and understanding of these measures and risk screening procedures.

Rating	Applicable HSF IDs
Met	All

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Comments
The daily communication meeting with senior staff is an opportunity to discuss patient accommodation and infection control strategies. There are single rooms with ensuite facilities that can be used for isolation purposes if needed. At the time of this assessment, there were several patients who had been isolated with Covid. Appropriate PPE was seen to be available. Ward visits confirmed that there are processes to apply standard and transmission-based precautions when these are indicated. Assessors observed laminated posters advising steps to be taken for airborne, transmission and standard based precautions.

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
Patients are provided with information regarding their health status including any identified infection. Patients and their family/carers are informed of the treatment and precautions that can be used to prevent and minimise the spread of infection. Patients Infection status is documented in their medical record and included in discharge summaries and transfer documents. Hand hygiene stations and signage were evident throughout all the units reminding visitors, patients and staff of hand hygiene as a preventative infection control measure. Data associated with infection compliance (hand hygiene) was noted to be posted on the Quality and Safety Boards which were strategically placed in public areas of each ward.

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
THPH has processes in place to apply standard and transmission-based precautions consistent with relevant legislative. Strategies include hand hygiene, personal protective equipment, cleaning and appropriate handling and disposal of sharps, all of which are the organisations' first-line approach to infection prevention and control. There was evidence on assessment of routine hand hygiene audits and meeting minutes where strategies to improve compliance were discussed.

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
Policy documents identify clinical procedures that require aseptic techniques. There was evidence on assessment of workforce training and competence in performing aseptic technique. Compliance with aseptic technique protocols is monitored by observational audit for competency. Audits of compliance were available and documented action plans implemented to ensure ongoing 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	
The organisation does not sterilise any invasive medical instruments onsite.	
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 hospital has its own cleaning staff. Protocols and guidelines are available to guide practice. Neutral detergents are used, consistent with products listed on the Australian Register of Therapeutic Goods. Review of cleaners' cupboards confirmed use of TGA approved cleaning products, the presence of chemical data sheets, and the use of different coloured mops. Linen is supplied by an external contractor and is transported in covered bins.	
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	
Clean and soiled linen was appropriately stored in all areas visited by the assessors and it was pleasing to see the consumer washing machines had instructions for cleaning each machine after individual use. The MSDS registers were up-to-date and located at the point of use.	
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	
All staff must have at least two COVID vaccinations prior to onboarding. An influenza vaccination program is available annually for all staff but unfortunately this is not given a high priority. There is little data kept on the number of staff who are vaccinated either at the hospital or externally.	
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
There are good controls and treatment action plans in place to minimise the incidents of health care associated infection to patients. Staff are encouraged to stay off work if they are unwell and there are processes in place to ensure an adequate workforce.

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
There is no reprocessing of single use or reusable items at THPH. Patient equipment is cleaned between use and labelled accordingly. On assessment re-usable devices were observed to be cleaned with appropriate wipes each time they were used. The organisation meets the requirements of Advisory AS18/07.

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
Antimicrobial Stewardship appears well managed by supporting policies and therapeutic guidelines. Antibiotic prescribing is monitored by the pharmacist during medication reviews. Infection rates are reviewed, monitored and presented at Medical Advisory Committee meetings. Antibiotic information is available by scanning a QR code. If patients have difficulty using the QR code information sheets are provided to patients who are prescribed antibiotics.

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
The policies and procedures for antimicrobial stewardship (AMS) align and comply with the Australian Commission on Safety and Quality in Health Care Antimicrobial Clinical Care Standards and Therapeutic Guidelines. The pharmacist works closely with the medical team to ensure appropriate antibiotic prescribing and administration.

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	
The governance of medication management is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles. Furthermore, training is linked to incidents by using a reflective practice tool and the outcomes of regular audits. Medication management is overseen by the Pharmacist and reported through the governance structure to staff and management.	
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	
Quality activities are used to evaluate medication management systems. A list of nurse-initiated medications is displayed in medication areas and a copy of staff names and their signatures were available. There is evidence that medication incidents are well documented and trended via RiskMan and are reported to the appropriate committees. The MAC meeting has medication as a standing agenda item and issues relating to the prescribing, dispensing and administration of medication are reviewed as required. REACH posters advise family/carers to contact staff if they are concerned about patients or their care.	
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	
Patients are provided with comprehensive information regarding their prescribed medication including any possible side effects and the reasons for any changes to their medication during their stay and on discharge. Medication was included in the daily bedside handover observed by the assessors ensuring patients were included in a discussion on their medication and any concerns were able to be identified and addressed. There are signs advising of medication times and the need for patients to wear their ID arm bands. Patients with known allergies were observed to wear a red arm band. The results of the Your Experience Survey are utilised to determine the patient experience of medication management.	
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	
There are policies and procedures in place for clinical staff to guide their practice in relation to prescribing, dispensing and administration of medication. Medical practitioners are appropriately credentialled to prescribe medication and position descriptions outline the scope of clinical practice for registered and endorsed enrolled nurses in the administration of medication. Nursing registrations are checked annually. The MAC meeting has medication as a standing agenda item and issues relating to the prescribing, dispensing and administration of medication are reviewed as required.	
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	
During the admission process patients and carers (if appropriate) are involved in development of the Patient Care Plan that includes medication management. Any change to medication is documented in the medical record and the Medication Management Plan.	
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	
Medication charts are checked at each handover between nursing staff and at bedside handover to ensure prescribed medication has been administered and orders in the medication charts have been entered correctly. Medication reconciliation is monitored by audits of the MMP. The audits indicate high compliance with medication reconciliation on transfer and discharge of patients. The discharge summary provided to the patients General Practitioner contains information about the care provided, changes to medications, current medication lists, medication management plans, and ongoing monitoring requirements	
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	
Any known allergies and adverse drug reactions are highlighted in WebPAS, recorded on the alert sheet in the medical record and on the medication chart. Red arm bands are used to alert staff to allergies or sensitivity to medications or topical agents, and known anaphylaxis to food, latex, or any other substance.	
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	
Medication incidents are documented in the patient's medical record entered into RiskMan and reviewed at appropriate committees. Serious incidents are tabled and reviewed at the MAC meeting. Patients and their family/carers are informed of any identified adverse drug reaction or allergy. An Adverse drug reaction sticker is placed on the medication chart to indicate any known adverse drug reactions.	
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	
Any suspected drug reactions are reported to the Therapeutic Goods Administration (TGA) via their website.	
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	
There is a standardised process underpinned by policies and guidelines to obtain a patient's best possible medication history (BPMH) on admission. It can include speaking to the patient, carers and referring GP to obtain an accurate list of the medication the patient was taking before coming into hospital. The BPMH is checked against prescribed medications and any reason for discrepancies documented. Nursing and medical staff are available to discuss issues or concerns both with the patient and their family/carer regarding medication management. During the patient's stay medications are reviewed during the multi-disciplinary clinical review meetings and daily clinical handover based on risk and clinical need.	
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	
The success of medication treatment is dependent on the patient's adherence to their medication regimen. Patients spoken to by the assessors were included in decision making regarding their medications and had a sense of ownership and felt included in medication management. The pharmacist supports both staff and patients in the monitoring of medication management. Nursing and medical staff are available to discuss medication that might include any associated risks to ensure patients and family/carers are able to make informed choices regarding available treatment options. Medication information is also available in other languages if needed.	
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	
Comprehensive information on the prescribed medication for each patient is provided to the treating GPs/Psychiatrists on the patients' medical discharge summary. Patients are provided with comprehensive information regarding their prescribed medication including any possible side effects and the reasons for any changes to their medication during their stay and on discharge.	
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	
Electronic and hard copy reference literature is available and easily accessible to support medication practice Clinical staff receive training in Medication Safety and Administration and High-Risk medicines. The medication error reflection form exists and is actioned as a non-punitive tool designed to help staff identify strategies that may avoid similar medication errors in the future.	
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	
All medication rooms were clean and secured with clear work benches. Restricted medications were appropriately stored, and the registers maintained. Medication management plans were evident in the files viewed by the assessors. Medication fridges are monitored to ensure appropriate temperature control and there are guidelines to be followed if the temperature deviates from the required range. There are good practices in place to guide storage and return of patients' own medications that included the use of colour coded bags that identified medications on discharge that were currently used and medications that were returned but no longer prescribed. The RUM (Return of Unused Medications) buckets that were in use in all the units visited by the assessors were the result of a quality activity for the disposal of expired and unwanted medications.	
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	
Interviews with staff and a review of documents supported the assessors' observation that high risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. Resuscitation trolleys were locked and checked daily.	
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	
There is a raft of Healthscope policies pertaining to this standard complemented by locally developed policies. On admission THPH utilises a standardised suite of clinical assessment forms. The assessment process is comprehensive commencing with the information received on admission and then followed by medical, nursing and allied health input. Clinical information is documented in the medical record and communicated via huddles, patient rounding, team reviews, and clinical and bedside handovers and forms the basis for ongoing treatment, ensuring patient needs are understood and considered in the planning and delivery of care. Clinical risks identified are added to the risk register and evaluated and mitigated. A Quality Management Plan viewed by the assessors outlined priorities and actions identified through peak committees. Terms of Reference, attendance, minutes and actions arising demonstrated that the governance structures are sound. ATSI cultural sensitivity guidelines are available with staff having access to cross-cultural awareness training. The admission documentation includes the opportunity to identify consumers of ATSI status.	
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
Comprehensive care is monitored through the review of audit results, incidents and patient feedback and the results are reported to appropriate committees. An audit schedule is in use outlining the frequency of each audit and action plans are implemented to improve outcomes. Audit results and trends contribute to overall quality improvement activities. It was pleasing to see audit results displayed in all units demonstrating transparency of practice and any areas for improvement noted and actions implemented. Audit results and trends contribute to overall quality improvement activities.

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
Patients' Rights and Responsibilities posters were seen throughout the hospital and also included in the Patient Information Directory that is provided to patients/families/carers via a QR code that is displayed in parts of the hospital. The Directory also outlines how patients can be actively involved in their own care and provide feedback on their hospital experience. Assessments and care plans should be completed with the patient, and when relevant their family/carer. Medical records viewed by the assessors in the recovery units included recovery-based care plans that were regularly updated but few included patient signatures that demonstrated they were part of the collaborative care planning process. Patient signed care plans were in the mental health medical records viewed by the assessors. Patient rounding, bedside handover and morning patient meetings provide daily opportunities for patients to be involved in their care and have concerns or issues addressed or clarified in a timely manner.
Suggestion(s) for Improvement
The 47-page patient information Directory was extremely comprehensive but had access and age limitations. It is suggested a small information booklet be available for patients/carers for each unit that provides basic information needed on admission and during a patients stay. It is also important to demonstrate that patients/family/carers have been part of the care planning process. If signatures are not included on the care plan it should be documented in the medical record that plan was discussed in collaboration with them.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.04	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Comments	
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. THPH offers an impressive raft of programs for inpatients and outpatients designed to meet the current needs of the patient population. The programs are regularly reviewed and evaluated to ensure they are appropriate and have the desired outcomes. The allied staff spoken to by the assessors were passionate about providing and being part of the therapeutic group structure at the hospital. The medical officer with the overall accountability for a patient's care is clearly identified in the medical record and patient care boards in each ward.	
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	
Multi-disciplinary care is well established, and the role of team members is well defined across the organisation. Staff from all professional groups and disciplines interviewed by assessors were able to articulate how multidisciplinary care works across the organisation. Annual staff reviews are linked to ensure all clinicians are appropriately credentialed and working within their scope of practice. There is an organisational chart that identifies clinical governance reporting lines and relationships.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
The organisation has invested in resources and tools to support decision-making and clinical pathways to deliver care. As well as the identified routine clinical handover processes, weekly case conferences are held for all patients during their admission. All members of the multidisciplinary team attend and contribute to determine the patients' status, goals and discharge planning. This was supported by clinical documentation and witnessed during multi-disciplinary meetings. Stickers easily identified which discipline had documented in the medical record.	
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
A Comprehensive Risk Screening tool is completed when patients are admitted and regularly reviewed or if there is a change in a patient's condition. The screening identifies cognitive, behavioural, mental and physical issues and risks of harm. Screening is audited for compliance. Education is provided to staff on the importance of completing all domains on the form that provide the foundation for a comprehensive care plan. The organisation meets 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
On admission all patients are routinely asked if they identify as Aboriginal or Torres Strait Islander. This information is entered into WebPAS. Although those who identify as Aboriginal and Torres Strait Islander patients are not high, it was noted support is given to identify accordingly.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
During the intake process patients are asked whether they have an advance care directive and if yes, they can bring the ACD or a copy when admitted for filing in their medical health record.	
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	
Risk assessment screening tools are completed on admission and at regular intervals to identify any potential risks during the patient's journey. The patient and their family/carer are important contributors to this process to provide any background information or any known triggers that can exacerbate a change in presentation. Risk screening processes are subject to audit and reports are provided through the governance structure. A review of clinical documentation by the assessors found risk screening documentation to be well completed across all wards. The organisation meets 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	
Assessment tools and resources are available at point of care for clinicians and education is provided on the use of the assessment and screening tools. The documentation audit identifies any areas of non-compliance with documentation of the screening and assessment and areas of non-compliance are identified and action plans formulated. It was pleasing to note routine outcome measures were collected and formed part of the routine assessment and identification of risk.	
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	
Following screening and clinical assessment any alerts or risks are documented in WebPAS, included in the medical record alert sheet and the patients care plan is updated as required. Alerts are also included on the clinical handover sheets and the patient care boards for inclusion and review at clinical handover.	
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
A comprehensive structured patient assessment is completed on admission and identified risks are documented and updated as required. The comprehensive care plan includes, if appropriate, a nominated support person to be involved in decision making regarding care and identified goals are documented as an outcome of the admission to hospital. The medical records viewed by the assessors included medical and nursing assessments, changes in clinical state, care provided and pertinent patient information to support the multidisciplinary team to deliver care. Regular documentation audits are conducted to ensure the medical records meet legal and professional requirements. Assessors witnessed interactions between staff and patients that demonstrated a partnership in care and decision making. Discharge planning was seen to commence at admission and included anticipated health care needs, to ensure a safe transition from hospital that may include outpatient or community programs for ongoing supportive care. The organisation meets the requirements of Advisory AS18/15

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
Any identified changes in a patient's behaviour, cognition or mental state are updated in the care plan and reviewed at the multidisciplinary case conference. Patients spoken to by the assessors were able to articulate the level of engagement in their care and expressed satisfaction that they actively participated in decision making at all points of care and review.

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	
THPH has established policy and procedures which clearly describe those who can be admitted within the context of the services provided by the clinic, and the mental health specialty service. Any potential end-of-life patient identified during pre-admission assessment is referred to a more appropriate care setting.	
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	
THPH does not provide palliative or end-of-life care. Staff are aware of EAP counselling support services for themselves and family/carers.	
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 (ACP) in place. The ACP then forms part of their medical record.	
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	
THPH does not provide palliative or end-of-life care, THPH do have supervision and support available for all staff through managers and access to EAP.	
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	
THPH does not provide palliative or end-of-life care, such patient are referred to alternate services.	
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	
THPH does not treat patients at end-of-life, such patients are directed to contact their GP to discuss appropriate care options.	
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
All patients have a routine pressure area risk assessment on admission, and this was evident in medical records viewed by the assessors. However, in the event of pressure injuries there is a range of equipment available to assist in the management of these injuries. Patients are encouraged to be active and appropriate exercise was seen to be included in the programs available. Although patients admitted to the mental health unit are ambulant, it is evident that the organisation is aware of possible risks and has an appropriate system to prevent, identify, report, manage and monitor any pressure injuries.

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
Pressure injuries are reported as incidents on RiskMan, with stages specified. Staff across the organisation have a good understanding of the reporting process and quality boards in the ward areas display incident data for staff and patients/carers to view. Incidents are trended and analysed at local, organisational and executive level.

Rating	Applicable HSF IDs
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Patients their families/carers are provided with relevant information specific to the prevention and management of pressure injuries on admission, during their stay and upon discharge. This information is included in patient brochures displayed throughout the units and included in the QR code Information Directory. Staff receive education in pressure injury identification, prevention and management.	
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	
Assessors were impressed with the work that had been done in relation to the management of falls underpinned by Healthscope Policies and Procedures. Falls screening commences on pre-admission by the clinical liaison team and this information is provided to the executive and assists in appropriate bed allocation at the morning bed meeting. Ongoing review and monitoring of falls data is presented at the ACHS Standard 5 working group and forms part of Healthscope's shared learnings. All patients admitted to the rehabilitation wards are assessed by the occupational therapist to support them to overcome the effects of any decreased functioning caused by their illness, ageing or accident. Although patients admitted to the mental health unit are mobile falls screening is still conducted and audited for compliance.	
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	
Falls prevention equipment to help reduce the risk of falls is readily available. There are a number of quality initiatives to assist in the reduction of falls and falls with harm including patient rounding, bedside handover, sensor mats and falls safety huddles. The implementation of coloured ''mobility tags'' that are displayed on all bedroom doors and mobility equipment are an excellent way of alerting staff that patients may need assistance or supervision to prevent falls. The patient care boards, and the clinical handover process includes discussion of patients identified as a falls risk. Patients can be allocated a bed near the nurses' station if needed for greater observation.	
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	
Information is available to patients, families and carers on falls and fall prevention. Items from home that can assist patients who are at risk of falls may be used during their hospital stay. The Physiotherapist and Occupational Therapist are involved in assessing patients and providing advice to both patients and caregivers of interventions and prevention strategies that can be used in hospital and when going home. Patient care boards indicate for staff and family and carers the level of assistance and any walking aids that are necessary. All falls incidents are reported and trended via RiskMan	
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	
No patients are admitted to the THPH overnight. All admissions are planned and patients are admitted during routine business hours.	
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	
Malnutrition screening is completed on all patients on admission that includes height and weight and an overview of eating patterns. Food allergies and any cultural dietary restrictions are documented in the patients' medical record and in WebPAS. Food and fluid charts are commenced to monitor intake if needed and patients can be assisted with eating and drinking if necessary. Patients and their families are advised they can bring special food items from home into the hospital providing they do not need to be stored or heated.	
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
THPH has policies in place to ensure that best practice approaches are adopted in the management of cognitive impairment and delirium. All patients over 65 years of age are screened for delirium and cognitive impairment and if two or more risk factors for delirium are identified the 4AT assessment for delirium and cognitive impairment is routinely completed. There were examples of non-pharmacological approaches to patients with behavioural symptoms of dementia and evidence of assessment of meetings aimed at ensuring that patients with dementia experience seamless service when moving from acute care, community and primary care.

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
For patients with cognitive impairment, adverse outcomes include being twice as likely to fall and experience pressure injuries, being readmitted to hospital and having longer length of stay. It was apparent during assessment that staff acknowledged and valued families and carers expertise and they role they play in determining treatment and ongoing care. Patients at risk of wandering or aggression were regularly observed and risk assessed. There were quiet areas in the wards providing a low sensory environment and a safe space. MDT reviews and discharge meetings ensure that patients who are suspected of having cognitive impairment have a comprehensive care plan that is sent to the patients GP and other relevant care providers on discharge. Carers receive information on cognitive impairment and the importance of their own self-care.

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
Identification of risk commences on intake and admission and is reviewed during the patient journey. Family and carers play an important role when obtaining a collaborative patient history to identify past or current suicidal or self-harm behaviours. During admission if there are concerns for patient safety, patient rounding is increased, and patients can be allocated a bed near the nurses' station to provide a higher level of care and increased observation. There is an identified risk assessment tool and attempted suicide, and self-harm is included in the risk register. Incident reporting including incidents relating to self-harm are monitored and reviewed to identify any opportunities for improvement. There are systems in place to enable family and carers to escalate care if they are concerned during admission about a patient's mental or physical deterioration.

Rating	Applicable HSF IDs
Met	All

ACTION 5.32
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Comments
The discharge summary includes an overview of the patient admission and outcomes of care and any ongoing concerns for safety.

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 are trained in WAVE for the de-escalation and management of actual or potential aggression. Sensory items and quiet spaces were observed in the mental health unit and provided a calm space to help patients regain control of their emotions in a low-stress environment. All patients have a routine risk assessment conducted during admission. Any potential risk of aggression is documented and included at the clinical shift handover. Patient care plans are reviewed and updated as required. Any incidents relating to aggressive behaviour are entered into RiskMan and reviewed for quality improvement purposes.	
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	
THPH does not tolerate physical or verbal aggression, or abuse towards staff, patients, family members or visitors. There are procedures in place which outline aggression risk factors and the need for de-escalation processes as the first response to aggression. Staff receive WAVE training in de-escalation techniques that include respecting personal space, making verbal contact and the identification of the patients wants and needs. If de-escalation is not possible and patients are unable to be nursed safely, they are transferred to a more secure mental health facility. During the assessment it was noted that the workforce had access to duress call buttons and a response system was in place for any incidents of aggressive behaviour. Posters displayed throughout the hospital advised that any form of aggression is unacceptable.	
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	
The aggression management procedure identifies the need for alternatives to restraint in the management of aggressive patients that include a comprehensive assessment on admission and daily risk assessments to determine the patient's mental health status. Restraint is not an accepted practice at THPH. If restraint is clinically indicated police or ambulance are called to transport the patient to a more secure environment.	
Rating	**Applicable HSF IDs**
Met	All

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

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. Staff interviewed were able to describe the processes for clinical communication and many processes including the bedside handover, group and MDT meetings, were demonstrated during the two-day assessment. All incidents and complaints relating to communication are reported and investigated through RiskMan.	
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	
Incidents relating to failure in clinical communication are reported through the incident management system and identified in patient feedback. Communication is patient centred and the importance of this being clear, current and factual was seen. The effectiveness of clinical communication, including handover is monitored through feedback and audit including the clinical handover audit with action plans developed for any areas of noncompliance.	
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	
The bedside handover in between the morning and evening shifts demonstrated a systematic approach to the handing over of patient information including medication management, treatment planning, goal setting and discharge plans. The bedside handover observed by the assessors involved patients and if appropriate their family and carers. It provided an opportunity to discuss ongoing care and to have any concerns clarified. Patients described to the assessors a high level of satisfaction with being included in the handover process. Care boards were in all bedroom areas and information was seen to be updated during bedside handover. Patient rounding was another practical example of staff being able to meet patient information needs, ensure patient safety and proactively address problems before they occurred.	
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	
Clinical communication is included in regular staff huddles, shift-to-shift handovers, bedside handover and the afterhours nurse manager handover. Appropriate guidelines are in place to continually check that patients are matched to their intended care and treatment. Any variation to this process is recorded and reviewed through RiskMan.	
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
Patient identification and procedure matching is well understood, and it is given appropriate attention by all staff. The patient identification and procedure matching system include the use of the three nationally approved identifiers for inpatients and outpatients. A white identity wrist band listing the three patient identifiers is worn unless the patient has an alert when the arm band is red. The inpatient bands used are consistent with the national standard. Patients are made aware of the protocol that staff are required to follow to establish correct personal identification. ID bands were seen to be checked during bedside handover each day and replaced when needed. All patients admitted to the mental health unit have identification photos attached to their medical record and medication charts. The patient photos were large and of good quality to assist in the patient identification process. Signed consent forms for photo identification were evident in the medical records viewed by the assessors.

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
During assessment, three patient identifiers were observed by assessors to be used at clinical handovers, medication administration and treatment procedures. There is a comprehensive audit schedule on patient identification and action items were available for any areas of non-compliance.

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	
The handover process ensures information relating to the ongoing care of patients is communicated at the change of every shift. The handover observed by the assessors was structured and met the needs of the staff who were active participants in the process. The clinical handover sheet used by staff provided prompts on any actions needed and demographic information about each patient. There was a flexible approach to handover whilst operating within a framework of good communication. The handover included any challenging patient behaviours or incidents relating to aggression, physical health or missed medication. A handover was given by the day staff to the afterhours nurse manager to ensure continuity of care across the hospital. As well as the identified routine clinical handover processes, weekly MDT case conferences are held for all patients during their admission. All members of the multidisciplinary team attend and contribute to determine the patient's health status, goals, and discharge plans.	
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
Communication was seen to embrace all aspects of care and across all domains verbal and written. From a governance perspective, there are a range of policies, guidelines and procedures to support the clinical handover process. Staff use a structured framework, ISOBAR and there is evidence of actions to increase the effectiveness of clinical handover. The care boards in the bedroom areas contained information on each patient including goal setting, diet, risk alerts and possible discharge dates and was updated as necessary and complimented the shift-to-shift handover process. Assessors attended several clinical handovers and observed the multidisciplinary patient centred approach to the handover of ongoing care. Clinical handover sheets used at shift handover were comprehensive and included diagnosis, history, risk investigation and any discharge plans.

Rating	Applicable HSF IDs
Met	All

ACTION 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Comments
The shift-to-shift handovers were done in a confidential area and in a timely manner. The situations where and when clinical handover should and do occur are clearly identified with resources available to facilitate a structured communication process. Whether a nursing or multidisciplinary handover, there were defined roles and responsibilities of clinicians and the involvement of the MDT in handover was well established. Alerts and risks are included in the regular huddles, bedside handover and patient rounding.

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
Assessors met with staff who demonstrated passion and commitment to providing evidence-based care and a commitment to partnering with patients and carers and to the principles and the philosophy of recovery in clinical service delivery. The REACH process is in place as one mechanism to contact clinicians and escalate care. Patients and families/carers can speak to staff at any time regarding any aspect of their care including bedside handover, family meetings and hospital visits. Results from patient surveys indicate patients are generally happy with their care and know how to communicate issues about critical information.

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
Assessors reviewed a number of medical records that were available at point of care, and found them to be well structured and integrated, and suitably organised to facilitate various regular audits of the medical record. Documentation by different clinical disciplines were highlighted by an appropriate identification sticker. A comprehensive care plan was completed on admission and identified risks documented and updated daily.

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
Policies and procedures consistent with the organisation's safety and quality systems are in place for blood management and the management of associated risks. Training is provided to eligible clinical staff with compliance reported at 87%. The organisation monitors the compliance and reports the compliance level on each ward's quality and safety boards. Education and training are scheduled when compliance is low.

Rating	**Applicable HSF IDs**
Met	All

ACTION 7.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Comments
The organisation monitors the blood management process in terms of blood and blood product utilisation, quality and safety and patient outcomes. After every blood transfusion event occurs for a patient, a formal audit is conducted to consider all aspects of the transfusion procedure. Since THPH maintains no blood storage fridges, there is minimal or no wastage. Ordering from the nearby Healthscope Norwest Private Hospital occurs, as and when blood is required for a transfusion. Reports are provided to the Healthscope Corporate committee and clinicians, and subsequently to State bodies.

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	
The organisation supports the engagement of consumers in care related to blood management including informed decision making. With blood transfusions averaging only 10-12 per year, there were no patients who had received blood / blood products available for interview, however, the assessors confirmed patient engagement in informed consent by checking medical records. A comprehensive Blood Transfusion Pack is provided to patients, which includes General Guides regarding Blood Transfusion for Patients, Families and Carers, which has been produced by the blood Watch Group that is part of the NSW Clinical Excellence Commission. A Patient Feedback form to assist THPH in learning from patients' experiences is available to consumers. Documentation provided to the assessors supported the level of engagement that occurs to ensure that patients are aware of the complexities regarding Blood Transfusion. There was mention of the Yarning about bloods that has taken place, and the consent that is required for Aboriginal and Torres Strait Island people. Information sheets are included in ward resource folders.	
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
The organisation's processes and policies support the clinically effective and efficient use of blood and blood products. Utilisation is monitored and action has been taken to minimise wastage and the inappropriate use of blood and blood products which is reported through the Healthscope Corporate committee. With a low number of transfusions occurring, namely 10-12 transfusions per annum, and blood sourced from the nearby Healthscope Norwest Private Hospital, there is generally no wastage of blood products. The organisation will not provide blood to patients with significant underlying health conditions and is not equipped to optimise the use of patients' own red cells.

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 in the clinical records and found evidence to support the effective documentation of decision making and transfusion details, including patient consent. The Blood Transfusion information recorded for each patient include that the patient has consented and has received information, the doctor responsible, cannulation details, type of blood product, start and end time, observations before, during and after the transfusion, the volume of the blood to be administered, and any adverse reactions. This is supported by quarterly audits of transfusion records, which are reported in the MARS electronic audit tool. Special attention has been given to an Iron Infusion Consent, which has recently been approved.

Rating	Applicable HSF IDs
Met	All

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
Policies, which are available in the Hint electronic policy management tool, are consistent with the national guidelines and national criteria for the prescription and administration of blood, and blood products are in place and available to clinicians. These are consistent with national guidelines and national criteria, and consistent with Healthscope corporate polices and guidelines. The details of all patients who receive a Blood Transfusion are reported in the RiskMan incident management system, however, there have been no incidents of adverse reactions related to blood management over the past 6 months.	
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	
Policies and processes are in place to support the reporting of adverse events related to transfusions, and in accordance with national guidelines and criteria.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Comments
Any reactions to blood transfusion are reported by the organisation in RiskMan, and to the relevant transfusion service provider, however, the low number of transfusion events mitigates against the organisation participating in 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
There are procedures for the transport and cold chain management including temperature control, to ensure that blood is handled and administrated in accordance with legislation and best practice guidelines. Processes are monitored and reported through the Blood Management Working Group, to the Quality & Risk Committee. Any incidents related to inappropriate handling of blood or blood products are reported and managed through the incident management system. The Blood Transfusion record that is maintained, details "stop" points to ensure that appropriate decisions are documented, and checks are made prior to, and during any transfusion occurring.

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	
Since blood usage is minimal, supplies are only ordered when a decision is made to transfuse. There is therefore no wastage of blood products.	
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	
Policies and procedures are in place for recognising and responding to acute deterioration. Staff were able to describe their role in such events. Risks and training needs are identified, and training reports were made available to members of the assessment team supporting that there was a high level of compliance by staff who have completed the Assessment and Management of the Deteriorating patient. The organisation has recently reviewed four policies relating to emergency, intra hospital transfers for rehab patients and mental health patients. These have now been amalgamated into one Escalation of Care policy, to include the Mental Health Deterioration Pathway for Rehab patients and Mental Health patients. This is a positive change and simplifies the process. There is an on-going focus on education and training, with the CMO providing training on the medications in the emergency trolley. The ALS training for designated staff, namely the nightshift in charge staff, After Hours manager and the MET call team had all been completed., and all CMOs are ALS trained. Regular BLS training sessions commenced for all staff on 1st July 2024. There is compliance with the requirements of Advisory AS19/1.	
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
In response to incidents related to clinical deterioration improvements have been made through the implementation of tools to assist staff. This includes the Track and Trigger approach to clinical deterioration. Observations are made for each patient on the SAGO (Standard Adult General Observation) charts that alert staff to any deterioration. Weekly sessions are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration and trends are reported to the Quality and Risk Meeting and to the Executive Committee. Shared learning occurs regarding cases of clinical deterioration.

Rating	Applicable HSF IDs
Met	All

ACTION 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Documents reviewed show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. There are reminders of the process to be followed by patients, carers and their families, and numbers to ring in the case of a patient deteriorating, posted in each patient's room. The REACH posters that are displayed throughout the hospital, have been modified, making it easier for patients to determine the appropriate action to be taken. The weekly Patient Forum that was attended by approximately 20 patients and carers during the Assessing period, demonstrated the benefit of drawing the patients and carers in attendance, to the REACH poster, and providing an opportunity to ask questions, and to survey the understanding of the process to follow should a person's condition deteriorate. There was special reference made to the fact that there are palliative patients cared for by THPH, and that there is shared-decision making regarding the end-of-life care decisions that staff are made aware of. These are recorded in relevant patient's medical records on an alert form.

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	
Patients who require close observation, are located close to the nurses' station to ensure their safety, and staff awareness of their ongoing condition. Vital signs are monitored in accordance with the policy that refers to the use of the patient's observation chart. Family and carers also play an important role in monitoring the condition of the patient/family members. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation/intervention. Where there are patients in the rehabilitation ward who have mental health issues, the mental health team are able to transfer them to the mental health unit or to a psychiatrist for specialised care.	
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, procedures and protocols support staff in identifying acute deterioration and the escalation of care process required. Discussion occurs during clinical handovers and safety huddles of any patients who have acutely deteriorated. Assessment and care planning documentation reviewed by the assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration and / or delirium. Clinical documentation is audited regularly and compliance with cognition screening is reported as being high. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members. The requirements if Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The organisation monitors performance of the identification and management of acute physiological, mental status, pain and / or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the assessment team, including the process for escalation of care where needed. Documentation reviewed identified policies, procedures and pathways are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. THPH transfers patients to the Norwest Private Hospital in the case of a deterioration in their condition. All staff are aware of the process to follow to prepare a patient for transfer in accordance with the local THPH policies and procedures. The requirements of Advisory AS 19/01 have been met (8.6 b,c,d,e).

Rating	Applicable HSF IDs
Met	All

ACTION 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Comments
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. The reinforcement of the meaning of the REACH posters in each patient room, during the weekly Patient Forum, is a most effective approach to stressing the importance of the process for reporting clinical deterioration of a patient.

Rating	Applicable HSF IDs
Met	All

ACTION 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Comments
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and the assessors were provided with documentation to support the evaluation of these processes which are reported through the Recognising & Responding to Deteriorating Patients Committee to the Quality & Risk Committee. During the Patient Forum in addition to a reminder of the process for reporting their or another patient's deterioration, they were reminded of the Emergency call bell that may be used.

Rating	Applicable HSF IDs
Met	All

ACTION 8.09
The workforce uses the recognition and response systems to escalate care
Comments
Staff were able to describe the systems in place to escalate care consistent with the organisations policy. Reports provided to the assessment team, and reported through the Quality & Risk Committee confirmed the effectiveness of these processes. THPH staff have an Emergency Procedure Guide that provides direction during an instance of mental or physical deterioration of a patient. Mock evaluation drills are held, which are a reminder for all staff of the process to be followed during an emergency.

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. All staff are BLS trained. CMOs and relevant After-Hours Managers and Shift Staff are ALS trained. CMOs also provide training for staff regarding the Emergency Trolley. There are policies for the escalation of care that outline the required skills and management for episodes of acute deterioration. CMOs are available at THPH during business hours and on call after 6 pm, to assist with acute deterioration.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency. Training records were made available to the assessors with a high level of compliance. The CMOs are all trained in ALS and there is generally, one on site. After 4pm, CMOs are on call. Should there not be a person available with ALS skills, staff are aware to call “222” emergency response. Staff were able to describe the process.	
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
There are policies that document the process if there is a need to transfer patients to a local mental health unit by ambulance for stabilisation, in the case of the patient not being able to be managed at THPH. There are mental health clinicians available to patients in the Rehabilitation ward to assess patients should this need occur. Interviews with clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. Staff were able to articulate the referral process for these patients. Staff have access to personal duress equipment in the case of an emergency. All incidents of self-harm and/or suicide are reported in the incident management system and are reviewed for opportunities of improvement. 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
There are criteria used to determine the acute physical deterioration of a patient, and the rapid referral to another service. Patients who need a higher level of care, following assessment, will be transferred to the Norwest Private Hospital by ambulance. Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to members of the assessment team and the effectiveness of escalation of care processes are monitored through the Standard 8 Recognising & Responding to Deteriorating Patients Committee, and to the Quality & Risk Committee.

Rating	Applicable HSF IDs
Met	All

Recommendations from Previous Assessment

Standard 1

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			
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	
Met with Recommendation	All	**Recommendation NS2 OWA 1121.1.22** The conditions under which CMOS are employed be reviewed to ensure that they experience regular formalised performance review. **Risk Rating: Low**	
Organisation Action taken			**Assessor's Response**
1.22- Establish annual performance review for 3 CMO's to be done by medical director. **Completion Due By:** 01/04/2023 **Responsibility:** Executive Assistant **Organisation Completed:** Yes			**Recommendation Closed:** Yes Two of the three CMOs have received annual performance reviews with the third CMO, who has been on leave, scheduled to be completed during the next week. A meeting with the medical director confirmed that these are now occurring on an annual basis. The Recommendation is now closed.

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 1121.1.23** Enhance the clarity of documentation outlining privileges which can be conducted at The Hills Hospital which are granted to medical staff. **Risk Rating: Low**

Organisation Action taken	**Assessor's Response**
Executive and GM updating Credentialing document. - Credentials amended for VMO's that had ticked TMS in their scope of practice. -Established Credentialing process for VMO scope of practice. -Established annual audit for VMO scope of practice. -Reviewed credentialed psychiatrist scope of practice and taken out TMS and ECT criteria from their credentials. Credentialing process is in place to capture the specific criteria. Variation to scope of clinical practice is established, if re credentialing with new scope of practice. -MARS audit annual VMO scope of practice. **Completion Due By:** 01/04/2024 **Responsibility:** Executive Assistant **Organisation Completed:** Yes	**Recommendation Closed:** Yes All of the actions required in the recommendation have been met. The Recommendation is now closed.