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

John Fawkner Private Hospital

COBURG, VIC

Organisation Code: 220189
Health Service Facility ID: 101268
ABN: 85 006 405 152
Assessment Date: 6 – 8 August 2024

Accreditation Cycle: 1

Contents

Introduction

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

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

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

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

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

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

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

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

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

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

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:
- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

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

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

Rating scale definitions

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

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

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

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

Repeat Assessment

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

For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.

Telephone: 1800 304 056

Email: AdviceCentre@safetyandquality.gov.au

Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

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

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

Conflicts of Interest

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

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

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Julianne Clift	Yes
Lead Assessor	Marrianne Beaty	Yes
Assessor	Victoria Daly	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for John Fawkner Private Hospital. The accreditation decision was made on 06/09/2024 and John Fawkner Private Hospital was notified on 06/09/2024.

How to Use this Assessment Report

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

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

The Ratings:

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

A rating report is provided for each health service facility.

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

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

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

Suggestions for Improvement

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

Recommendations

Not Met/Met with Recommendation rating/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

John Fawkner Private Hospital underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 06/08/2024 to 08/08/2024. The NS2.1 Short Notice Assessment required three assessors for a period of three days. John Fawkner Private Hospital is a Private health service. John Fawkner Private Hospital was last assessed between 06/12/2021 and 09/12/2021.

PICMoRS was used to conduct this assessment, with 85% of available time spent in operational areas during this assessment.

OVERVIEW

John Fawkner Private Hospital (JFPH) located in Coburg, Victoria is part of the Healthscope Group. This hospital is housed in a very old facility that has been mostly renovated, but still has more work to be undertaken to provide the space and modern facilities associated with more contemporaneous hospital buildings. Having said that, staff and the renovated areas together with the overall cleanliness of the hospital is what makes the environment pleasant and appropriate for healthcare delivery. Located within the Melbourne suburbs, it is close to Royal Melbourne Hospital and its' sister service of Melbourne Private which both provide tertiary services when the need arises, including Mental Health. This hospital primarily cares for the community in Coburg and surrounds, including an Emergency Department and extensive medical and surgical services, including oncology.

PICMoRS methodology was used to ascertain information from the staff along with patient journeys, medical history reviews, high risk scenario testing, clinical handovers/surgical safety timeouts, and walkabouts in every part of the service. Approximately 85% of the assessors' time was spent interviewing staff and patients admitted during the visit and using a variety of methods following patients throughout the internal processes. The hospital provides an excellent service for the local population and within the scope of the very skilled and dedicated health care and support teams. All assessors felt they would be happy to be cared for by these staff and within this facility which engendered a feeling of care and dedication to their community. There was a 'relatively new' Executive team which have undertaken much work since the past accreditation survey and lessons learned from that experience resulted in a culture of willingness to take on board any suggestions as they arose during the actual assessment. As a result, there was no need to provide any recommendations for this organisation with all suggestions implemented within hours or days.

CLINICAL GOVERNANCE

The Clinical Governance systems of JFPH are well established in line with the Healthscope Corporate Office. Clear leadership was evident throughout the organisation and the organisations values were reflected by all staff the assessors met. The Healthscope Board has a sound understanding of their role and of the risks and challenges facing all their hospitals including JFPH. Assessors appreciated the responsiveness of staff and consumers they met throughout the week. Staff were well prepared and voluntarily approached members of the assessment team, keen to provide any information for the accreditation assessment. There are a range of clinical guidelines that are multi-disciplinary, and evidence based accessible via HINT (the Healthscope intranet site). The facilities visited were clean and well maintained by support services staff. The hospital provides a welcoming environment for Aboriginal and Torres Strait Islander people, with a local Aboriginal art displayed as well as posters asking First Nation's People to identify. The hospital did have approximately 0.3% of their patient population identify as being First Nations, with a total of 67 presentations in the past year compared

with the LGA Census revealing a 3.8% people identifying as Indigenous in the local area. Aboriginal and Torres Strait Islander flags were sighted at the entrance to nearly all departments within the

hospital. Clinical governance was very strong within this new Executive Team and the managers of all the departments.

PARTNERING WITH CONSUMERS

JFPH has demonstrated it works in partnership with consumers at the individual, ward / department, and wider service level. There is a Consumer Engagement Plan. They are assisted with Consumer Partnerships at the Healthscope Corporate level. There are quality improvement projects conducted by the consumers. Patients were very satisfied with their experience and the consumer consultant felt they were supported.

INFECTION PREVENTION AND CONTROL

There are well established contemporary infection prevention strategies that are reflected in the policy and through the contract with Healthcare Infection Control Management Resources (HICMR). Training of staff is reflected in the high completion rates of the various training modules. The program is well coordinated and demonstrates ongoing quality improvement through projects undertaken in response to audit findings. There is ongoing consumer engagement with ongoing focus on educating both patients, their families, carers and visitors. JFPH is well supported by the CSSD, and the systems and processes in this area. The antimicrobial stewardship initiative at JFPH is maturing into a multidisciplinary program with the support of the Pharmacists and Infectious Diseases Physician.

MEDICATION SAFETY

The Pharmacy Service at JFPH is in partnership with the outsourced service of HPS. This service is excellent and is closely aligned to the values and service of the Healthscope group. Strong leadership amongst this outsourced service, its employees and those of JFPH, resulted in a very responsive, appropriately managed and monitored medication safety service that addressed both the needs of the hospital as well as that of the patients/carers. JFPH has all the appropriate systems in place to promote medication safety covering procurement, storage, administration, dispensing, as well as monitoring the effects of medicines and education information. All wards have a pharmacy room which contains a medication fridge which is monitored remotely back-to-base. Timely clinical reviews occur by the clinical pharmacists within one day of all admissions, and medication reconciliation is provided by the clinical pharmacists within 24 hours.

All patients are educated by the Pharmacists about their medications, particularly any new medications or any changes in their medication regime at the time of discharge. They are also supplied with a complete and accurate medication list, and one is uploaded to the My Health Record (MHR) if the patient has not opted out of this system. A medication committee oversees all the monitoring and reporting of medication safety and Quality Improvement Activities (QIAs) are initiated if any action is required to reduce any identified opportunities for improvement across the whole hospital.

During the assessment it was discovered that some nursing staff took keys to the patient's medication drawer home each day and brough them back for the next shift. The organisation immediately addressed this situation by putting out a direction that no patient medication drawer keys were to leave the hospital, and immediately implemented a system for assigning and collecting keys from nursing staff at the start/end of each shift. This immediate action prevented the assessment team having to write a recommendation to that effect.

COMPREHENSIVE CARE

JFPH has identified and mitigated risks associated with comprehensive care. There are mandatory and area specific training that have good compliance. Patients interviewed said they were involved in shared decision making and this was supported by the Comprehensive Care audit results. The Clinical Risk Screening and assessment tool is comprehensive and identifies further actions required to mitigate identified risk and develop an individualised comprehensive care plan. There has been a focus on the risk of Delirium and the gap analysis was recently reviewed and updated. Whilst on assessment the assessors noted that some staff were unaware of using one risk factor to complete the 4AT and a Quality Improvement, education and completion of the tool was undertaken before the end of the visit. Advanced Care Plans are collected and patients without an Advanced Care plan can be provided with information and assisted to develop one if appropriate. Arrangements for Palliative care is robust. Initiatives to better manage falls including appropriate location and supervision are working well although reducing the incidents of falls is recognised as a challenge.

COMMUNICATING FOR SAFETY

Huddles, and clinical and procedural handovers were all observed and well organised with clear and critical information handed over. Patients confirmed that three points of identification are used, and this was evident during observational audits. Patient Care Boards were visible and gave patients, visitors and staff information on various aspects of care. Team time-out was observed in theatres. JFPH consumers are working in partnership with the hospital to improve the meaningfulness of the patient care boards.

BLOOD SAFETY

The Blood Management Committee has an engaged and supportive multidisciplinary team and a range of policies and procedures covering blood and blood product management are available to the clinical workforce. Quality improvements such ensuring the consent is correctly filled out and appropriate checks are done by two staff individually have recently been undertaken. The pathology and nursing staff report adequate supplies of blood and prompt delivery, and the ordering and administration includes a comprehensive checklist. Policies, patient information, training and haemovigilance are evidence based and consistent with best practice. Whilst there were minimal transfusions during the site visit one assessor did observe a patient receiving packed cells. This enabled observation confirming that the policies governing safe management of blood and blood products are used in practice.

ACUTE DETERIORATION

Appropriate systems are in place for Recognising and Responding to Acute Deterioration. There is timely response from the MET team who have the skills and knowledge to provide care and there are procedures for rapid referral of patients to services that provide best care of acute deterioration. Families and patients are made aware of the 'If You Feel Worse " process to escalate care if they are worried or concerned and this is monitored by the health service.

Summary of Results

John Fawkner 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

John Fawkner Private Hospital

Site	HSFID	Address	Visited	Mode
John Fawkner Private Hospital	101268	275 Moreland Road COBURG VIC 3058	Yes	On Site

Contracted Services

A sample of Contracts have been verified.

The following contracted services are used by John Fawkner Private Hospital.

Provider	Description of Services	Verified During Assessment
Clinical Laboratories Pty Ltd	Pathology	Yes
NationWide Parking	Car Parking	Yes
I-MED Radiology Network	Medical Imaging	Yes
ED Specialist Services Pty Ltd	ED Specialist Services	Yes
Dorevitch Pathology	Pathology	Yes
Chemtronics Biomedical Engineers (Corporate)	Biomedical equipment	No
EcoLab (Corporate)	Chemicals for housekeeping and catering	No
Cleanaway	Clinical Waste	Yes
Cleanaway	Confidential Waste Management	Yes
HICMR Pty Ltd (Corporate)	Infection Control Consultants	Yes
Linen Services Australia	Linen	No
Coregas (Corporate)	Medical Gas Supplies	No
HPS (Corporate)	Pharmacy Services	Yes
Blue Sky	Theatre Cleaners	No
Ecocycle Pty Ltd	Battery Recycling	No
Daniels Health	Sharps Containers	Yes

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

Standard 1 - Clinical Governance

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

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
The Healthscope Board is the governing body and is supported by Board sub-committees that provide leadership and strategic direction to the organisation. The JFPH Executive team provides operational and clinical leadership to hospital staff and Visiting Medical Officers (VMOs). The Healthscope Clinical Governance Framework describes the governance related roles and responsibilities across the services and supports staff to effectively partner with patients and families. The JFPH Committee Structure has been established to monitor the effectiveness of the clinical quality system through audit, data analysis and incident reporting. A risk management approach underpins all aspects of clinical safety and quality. There are also Consumer Engagement and First Nation's Engagement Plans in place to ensure strategies are undertaken to improve both participation with patients & their family, consumers and First Nation's People. JFPH has Clinically and Culturally focused 'Dashboards' to report this information to staff and stakeholders of the service. The hospital is proud of their values of constantly striving to improve and grow. They were very proud of their staff and the solid foundation of excellence of clinical outcomes for their patients. Risk and quality management align with the aspirations of Safer Care Victoria and learning from both mistakes, near misses and experience. So much so, there are standing agenda items on committees throughout the organisation for sharing lessons learned with all staff and stakeholders.

Rating	Applicable HSF IDs
Met	All

ACTION 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Comments
The Aboriginal and Torres Strait Islander or "First Nation's" population within the catchment area for JFPH is less than 4.0% and is below the state average for Victoria. An audit of internal monitoring to capture our First Nation's people, by asking the question of all potential patients if they identify as being of First Nation's origin, indicates high levels of compliance and few presentations by First Nations people. Of the 22,209 patients treated at JFPH last financial year, only 67 patients identified as First Nation's People, meaning only 0.3% of all patients treated were of First Nation's ancestry. All members of the Executive Leadership Committee (ELC) were able to describe how the specific needs of First Nation's People are being addressed. The organisation meets the requirements of advisory18/04.

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
JFPH uses the Healthscope Clinical Governance (CG) Framework which is fully endorsed by the Healthscope Board. Senior managers and staff in key clinical governance leadership roles were able to describe the organisation's Clinical Governance Framework. Senior managers were also able to demonstrate to the assessment team how the CG Framework is used within both JFPH and across all Healthscope organisations. The ELC and senior managers were able to describe how its effectiveness is monitored and reported, predominantly through meetings of the ELC, Patient Care Review Committee (PCRC), the Quality Committee (QC) and the Medical Advisory Committee (MAC) within the hospital and 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
As noted at Action 1.02 the First Nation's People population within the GORH catchment area is less than 4.0% and is below the state average for Victoria. Interviews with staff and managers were supported by documentary evidence confirming that the organisation has strategies in place to monitor identify First Nation's people who present for care and results indicate low numbers commensurate with the First Nation's People population within the catchment area. A report on First Nation's Performance Indicators is regularly presented to the ELC as well as to the Healthscope Board of Management.

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
Documents reviewed by the assessors including minutes of the ELC, and PCRC, QC and MAC, along with interviews with senior managers confirmed that issues of safety and quality are key factors in the organisation's business decision making. Currently, JFPH are awaiting delivery of the components of robotic surgery for knee and hip replacements now that the surgery is becoming more commonplace and much safer in response public demand for these services. This has also been facilitated by young up and coming Orthopaedic Surgeons who are developing the skills currently available for this surgery and are ready and willing to introduce this within JFPH. The hospital is hoping to roll out the education and training required for all staff involved in the process within the year.

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
The Executive revealed that the local facility's rules dictate the terms of the establishment. The MAC requires good representation of each speciality service, and particularly the dominant specialties. All the members of the MAC do this on their own time and all volunteer their services. A review of documentation, reinforced by assessor observations and interviews with staff, verified that they work within the governance framework. Position Descriptions describe the requirements and expectations of all staff for safety and quality. Staff confirmed that they understood their clinical safety and quality responsibilities and were able to articulate how the organisation monitors, reports and evaluates performance through a range of systems and processes including regular audits, complaints, incident and quality improvement monitoring and reporting to name a few.

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
Documents reviewed, together with interviews with the senior managers demonstrated how policy documents, procedures and protocols are managed to ensure that they are current, comprehensive, effective, appropriately referenced and comply with legislation and regulations, as well as with State requirements such as Safer Care Victoria related to Statutory Duty of Candour and Open Disclosure which has been mandatory since July 2022. Compliance monitored through incident reporting and trends which influence the revision of specific policies, procedures and protocols where indicated. A risk management approach was evident in defining the scheduled revision of key documents.

Rating	Applicable HSF IDs
Met	All

Org Name   :   John Fawkner Private Hospital
Org Code   :   220189

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 each ward's Quality Board and public display of their progress against benchmarks etc. Minutes of ward team meetings and at all levels throughout the organisation demonstrate the distribution of this information to ward staff. 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.

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 are provided to the ELC and senior management, the workforce, consumers and other stakeholders. Reporting is undertaken through a range of appropriate mechanisms, and in formats that are appropriate to the intended audience examples being the Quality Boards in each department for staff and the annual Quality Account for consumers.

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 ELC and leadership teams to define and operationalise the risk management system. Documents reviewed, plus interviews with staff, confirmed that all staff are encouraged to report any incidents or "near misses" through the incident reporting system. The Quality & Safety Team provides analysis and feedback to all staff via RiskMan and KPI reports and to key committees on incident reporting and trends. Trend analysis of incidents drives quality improvement activities and 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 1.11
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 and especially any "near misses" through the RiskMan incident reporting system. Patient's spoken to reported that they felt empowered to raise concerns. Brochures and posters are located throughout the organisation describing to patients and carers how to escalate care. These were based on the SCV "If you feel worse, tell a Nurse!". The same information provides data for each department's Quality Board which were well read by the assessment team as well as family and visitors.

JFPH have an 'Incident Reflection Tool' which staff are required to complete following a clinical incident and the 'learnings' are shared across the whole hospital as well as with Healthscope to encourage continuous improvement in patient safety. This is consistently applied with staff being able to articulate their experience with this process. |

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 which is consistent with the Australian Open Disclosure Framework. Open Disclosure training is mandatory for all clinical staff as a once off. The organisation monitors how, why and when open disclosure occurs. Staff were able to articulate their role in open disclosure and felt supported in initiating and participating in open disclosure. Managers undertaking open disclosure are encouraged to ask consumers how they think a recurrence may be avoided. The Open Disclosure process also forms part of the Statutory Duty of Candour within Victoria.

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
JFPH 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. JFPH uses many opportunities to seek feedback from consumers and their family/carers including pos-discharge surveys, complaints and consumer feedback forms which are located throughout the organisation. Staff are encouraged to complete the annual People Matter Survey. Feedback is analysed, trended, and reported within the organisation.

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 is established, and 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 way. Feedback is provided to the ELC, PCRC, QC as well as the workforce and consumers on the analysis of complaints and action is taken to inform improvements both in response to individual complaints where indicated and based on identified trends which also inform the risk register.

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. Intake processes include an assessment to identify vulnerable and isolated clients. A risk screening tool is in place to assess the level of risk to staff members providing services in the community and processes are in place to ensure their safety. This includes requiring people seeking care to come in the health service if the risk of providing care in the home is considered too high.

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
JFPH uses a paper-based health record for inpatients including the Emergency Department. Records are readily available to clinicians at the point of care and organised in such a way as to support accurate, comprehensive and timely documentation. Clinicians were able to describe how they use the healthcare record to Assessors and records reviewed by members of the Assessment Team appeared complete. Healthcare records are maintained securely and comply with privacy legislation. The medical record department is well managed and responsive to the needs of the organisation. Unfortunately, due to the size of the existing buildings and age of the infrastructure where the Medical Record Department is located, (on the first floor of an adjacent building) the process of retrieval and storage is very manually labour intensive, and the majority of records are located off site in secure storage facilities. This means that the rate of retrieval of medical records is high and therefore also expensive. Special rules have been put in place to minimise the risk of manual handling of these records which require them to be carried up a spiral set of stairs to another floor by an orderly.
Suggestion(s) for Improvement
Continue to search for a more appropriate location for the storage of medical records in the interim before a EMR is finally utilised within JFPH.

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
JFPH has systems in place to allow access to My Health Record and these systems ensure that only those staff with the necessary credentials are allowed access. 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
JFPH has systems in place that provide information to My Health Record that meet the requirements of the Victorian Department of Health. 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
Assessors reviewed comprehensive documentation detailing the orientation provided to members of the governing body, Visiting Medical Officers (VMOs), staff, contractors, locum and agency staff, and students. Each group has the relevant training identified for their quality and safety roles and responsibilities, and contracts and position descriptions further supported this. Assessors were advised that following appointment junior and very new staff are 'buddied' with another staff member for an initial period dependent on the individuals' skills and experience following appointment and on-going support is available if necessary.

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
Policies and 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 within the facility. It is reviewed in accordance with policy and when required to accommodate new / altered procedures or technologies. When discussing the mandatory training system assessors noted that JFPH has set a target of >90% for compliance with mandatory training and that a number of training modules fell below the required expectation. Throughout the year monthly compliance with a few mandatory training modules reported in the Clinical Dashboard ranged between 53% and 100%. Due to staff leave and other factors it seems unlikely that a target of >90% compliance with all training modules is achievable.
Suggestion(s) for Improvement
Consider the target for mandatory training and the system of monitoring compliance to determine whether the current target is achievable and revise the targets if indicated.

Rating	Applicable HSF IDs
Met	All

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
An Aboriginal and Torres Strait Islander Cultural Awareness program is part of the annual training program and consists of a half hour face-to-face session. The compliance rate for participation in cultural awareness training is set at 100%. The current completion rate sits at 85% and as noted at Action 1.20 may not be achievable. However, Healthscope (including JFPH) have a 'First Nation's Engagement Plan' and has formed a collaboration with Sunshine Hospital Aboriginal Liaison Officers (ALOs) who have provided JFPH staff with face-to-face educational workshops which were provided by First Nation's People, and this is now a part of the local orientation program moving forward. JFPH takes this opportunity whenever it presents itself and is determined to improve opportunities for First Nation's patients and workers within the organisation. NAIDOC and other significant First Nation's People events are also celebrated across the campus.
Suggestion(s) for Improvement
1. Consider the target for cultural awareness training and the system of monitoring compliance to determine whether the current target is achievable and revise the target if indicated.

2. Continue to identify opportunities for recruiting First Nation's People onto the staff. |

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
As with mandatory training, JFPH has set a target of 100% for all staff to have participated in an annual performance review. Throughout the year monthly compliance ranged between 57% and 73%. Once again, compliance with the current target may not be achievable. Staff stated that they were keen to go through this process as it often identified opportunities for ongoing education and training that often can lead to promotion in the future.
Suggestion(s) for Improvement
Consider the target for annual performance reviews and the system of monitoring compliance to determine whether the current target is achievable and revise the target if indicated.

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 professional groups, guided by policy and procedures consistent with National Standards. The process for defining scope of is monitored and regularly reviewed and individual scope of practice is reviewed and revised in accordance with policy. All registered clinicians must make an application through 'CGov' at the expiry of their period of credentialling, and must provide evidence of appropriate insurance, Craft College and APHRA registration and referees. JFPH's MAC oversees this process and ensures that clinicians don't get credentialed if their skills are not involved in the scope of the hospital. An example currently is that JFPH will soon be implementing robotic surgery for knee and hip replacements, so only then will those clinicians with the appropriate skills and experience will be considered to practice within this hospital. JFPH provides endoscopy services and the requirements of Advisory 18/12 have been met.

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
Credentialing of medical staff is overseen by MAC as stated previously. The MAC makes recommendations to the General Manager and to the Medical Director in respect of provisional credentialling decisions made. Credentialling processes are very well established and managed with a supporting policy which is reviewed regularly. 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. Recredentialing is undertaken three - five years, depending on the specialty.

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
Many various staff of JFPH were interviewed by the assessors were able to articulate their roles and responsibilities for quality and safety. These are defined in both the position descriptions for staff employed by the organisation and in contractual arrangements for the provision of agency and locum staff. Orientation and onboarding include information for staff on these responsibilities. See also action 1.19 for information on the orientation processes.

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 organisational structure. All staff spoken to advised they feel supported by JFPH and were satisfied with access to after-hours support and advice available through on-call medical staff, their colleagues in Melbourne Private, Healthscope and the Executive-On-Call.

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 utilises the Healthscope Intranet (HINT) site to provide clinicians with access to a range of tools, best practice guidelines, care pathways and the Clinical Care Standards (CCSs) to support their clinical practice. A gap analysis has been performed to many of the CCSs that are relevant to JFPH, and changes are being or have been implemented in line with these standards. The organisation is compliant the requirements of Advisory 18/12 as well as with ACSQHC Fact Sheet 11.

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. Audits are reported monthly to the Quality Committee and the Patient Care Review Committee, and the craft groups are expected and required to develop and implement action plans where results do not meet expectations. Where clinical variation is identified a risk management approach is used to minimise harm from unwarranted variation.

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
Safety of the environment is considered in service planning and design. A review of safety and quality documentation substantiated by 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 with the intention of ensuring that they are fit for purpose. During an environmental walkaround assessors noted that Material Safety Data Sheets are located in all cleaners' cupboards and other locations where chemicals are located. Assessors further observed the storage of boxes and items of machinery or equipment in front of doorways in the theatre suite which could be very dangerous in fire situation and could impose a risk to the safety of staff in a fire emergency. This was immediately addressed by the Executive within hours of notification, but the assessment team feels that a more strategic approach to this problem could ensure recurrence does not occur. The assessment team were provided with an action plan on how the problem of storage of theatre equipment can overcome space availability in the future.
Suggestion(s) for Improvement
Continue to implement the action plan to continually ensure a clear pathway in the theatre fire exists in the future.

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 that have a high risk of unpredictable behaviours and also 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.

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 both internally and externally is clear and fit for purpose. The assessment team were able to successfully navigate an unfamiliar environment with little or no assistance and consumers observed did not require assistance on the majority of observations.

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
Reasonably flexible visiting arrangements are in place for most patients, and very flexible for sicker and palliative care patients. This was verified by comments from patients about their satisfaction with the current visiting arrangements.

Rating	Applicable HSF IDs
Met	All

Org Name   :   John Fawkner Private Hospital
Org Code   :   220189

ACTION 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Comments
The organisation demonstrates a welcoming environment and recognises the importance of the cultural beliefs and practices of the First Nation's People. Specific examples include Aboriginal and Torres Strait Islander flags and a large piece of Aboriginal Artwork at the entrance to the JFPH. There was a small print of the Aboriginal Tribal Grounds in the entrance also, but this was a bit small to promote a welcoming environment for First Nations people.
Suggestion(s) for Improvement
1. Undertake a welcoming environment review that recognises the beliefs and practices of First Nation's People and undertake improvements as indicated by the review outcomes. 2. Consider providing a much larger map of the Aboriginal Tribes across Australia which always seems to be the centre of attraction wherever it is utilised.

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
JFPH has policies and procedures in place to support partnering with consumers. Interviews with staff and patients demonstrated that the principles of safety and quality are applied. There is a Partnering with Consumers Committee in place and Consumers are engaged in policy development, implementation and training. The consumers are actively involved in hospital quality improvement programs that minimise risk. The Committee reviews patient incidents for input and the patient experience surveys. Staff receive training in the following areas and compliance is: • Working with Respect – 77% • Relationship Centred Care – 85% Patient stories are included in the training.

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
JFPH demonstrated that they are committed to improving partnering with consumers at all levels. There is a Partnering with Consumers Committee that monitors progress that is reported up to the Governance levels of the health service. Monitoring includes patient satisfaction surveys and projects to improve partnerships. These have included a review of the 'Patient Care Boards' and the development of a patient introduction brochure. JKPH consumers are members of the corporate Partnering with Consumers Committee, and some have done projects with Safer Care Victoria (SCV).

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
Throughout JFPH you can find copies of the Commissions 'Charter of Healthcare Rights' displayed. JFPH has a 'Rights and Responsibilities' brochure for patients. These documents are readily available throughout, and staff ensure that they can be easily accessed and understood. The brochure has been reviewed by consumers using the service.

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
Interviews with staff responsible for informed consent for both procedural and financial were conducted. Staff understood their responsibilities with respect to informed consent. The consent policy 'Consent for Medical/Surgical Treatment' complies with legislation and reference best practice. Compliance with consent is audited and the results for the 2024 audit is 85%. Two of the clinical wards achieved 100% for this audit, other areas varied from 60% to 98%. Action plans are in place for any results less than 90%. The requirements of Advisory 18/10 have been met with respect to informed financial consent. There are packages available for the administration and consent to the use of blood and blood products.

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
JFPH assesses patients on admission and as part of that process the staff can establish a patient's capacity to make decisions regarding their own care. There are systems in place for those patients where a substitute decision maker is required. Staff were able to explain this process, access the relevant policies and refer to appropriate services as required. JFPH is in the process of removing the NOK from the financial consent form, to meet legislative requirements.

Rating	Applicable HSF IDs
Met	All

ACTION 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Comments
The assessors met with a number of patients and clinicians who confirmed that staff worked with both the patients and as required the substitute decision maker to ensure there was shared decision making about their care planning and in determining the patient's goals of care. Goals of care are displayed on the patient care board and in the comprehensive care plan.

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
Patients and carers interviewed at JFPH confirmed that they are actively involved in their care. Satisfaction surveys are conducted, and the results are monitored by the Partnering with Consumers Committee and reported up to the Patient Care Review Committee. The reports indicated that patients are satisfied with the level of engagement in their care. Staff and patients could describe how they are involved in their care, including carers.

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
Information for patients and carers are provided in several ways, ranging from consumer endorsed brochures to the 'Patient Care Boards', and Consumer Newsletter. The consumers on the Partnering with Consumers Committee have several projects underway to make improvements. Examples include: • The 'Patient Passport.' This is a brochure that introduces the patient to their room, particularly as most patients arrive to their room post-surgery. • The patient escalation process – where patients are encouraged to 'tell the nurse if they feel worse'. • The 'Patient Care Boards' looking at what would make sense to a patient. All brochures go to the Partnering with Consumers Committee for comments and feedback and endorsement. Brochures are available in languages relevant to the community that JFPH serves. The consumers were involved in the review of the 'Reconciliation Action Plan' that has now been endorsed by Reconciliation Australia. Patient satisfaction with communication and information provided to them is included in satisfaction surveys.

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
All documentation that was reviewed by the assessors at JFPH, and with discussions with consumer representatives, confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs. All brochures viewed had a 'Consumer Approved Publication' tick.

Rating	Applicable HSF IDs
Met	All

ACTION 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge
Comments
The clinicians at JFPH were able to articulate a situation that involved how they effectively partnered with a patient in their care, including the family and as required a multidisciplinary team. This is part of the planning for the safe discharge of patients to home. Patient information is available in other languages as required for their demographic of Italian and Greek patients. Patients and carers supported that they felt information was provided to them in a manner and format they could understand. As a private hospital, many surgeons had pre-prepared packs for their patients regarding follow up and care for their procedure.

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
The assessor met with members of the Partnering with Consumers Committee. They were able to articulate their active role in the governance and evaluation of health care at JFPH, and one member was also represented on the Corporate Healthscope Partnering with Consumers Committee. Members also played a role on a range of key committees and groups within JFPH, including, Medication, Acute Deterioration, Communication, Blood, Comprehensive Care, Infection Control and the Quality Committee. All consumers receive orientation to their role within the organisation. Patient Stories are shared at the meetings. Several consumers participate in staff training, for example the disabled patient. JFPH uses various mechanisms to gain feedback from a range of consumers.

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
Interviews with consumer representatives at JFPH confirmed that they are well supported in their role. They receive orientation, including one of their consumers being part of the education team. The consumers were very happy with the level of support that is provided to them, and that JFPH were keen to partner with them on projects to improve information and improvements in care giving. Any identified areas of knowledge gaps for consumers, JFPH supported them with education such as interpretation of data/reports.

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
Admission of First Nation's People was 0.3% in 2023 (67) admissions. JFPH has developed relationship with Western Health to conduct workshops for staff from Western Health's Aboriginal Liaison Officer. Consumers participated in the development of the Reconciliation Action Plan, that has been endorsed by Reconciliation Australia. There is a brochure 'Aboriginal Liaison'. Aboriginal artwork is displayed throughout the facility.

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
The JFPH consumers have participated in several training modules. This includes an outline of some of the difficulties a disabled patient may encounter as a patient, conducted by one of the consumer representatives who is disabled. Some examples include: • Patient stories are utilised in training to educate the staff. • Diversity training is mandatory. • Working with respect training – 77% completion • Relationship Centred Care training – 85% completion . • Healthscope is currently using a video as part of webinar training to explain the consumers role.

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
JFPH has governance systems in place from Corporate Healthscope to the governance structure within JFPH. This includes an Infection Prevention and Control Committee that reports to the Quality Committee. There are a number of IPC policies and procedures. JFPH have a contract with Healthcare Infection Control Management Resources (HICMR) who provide current policies and procedures for JFPH and a number to toolkits and auditing tools. There is an Infection Control Coordinator and a representative from HICMR who conduct audits. There is a schedule of training for staff in infection control and auditing incorporate risk assessments and gap analysis have been conducted in key infection control areas. As required action plans are put in place to ensure areas of noncompliance are addressed. Discussions with staff, they were able to articulate infection control processes such as use of signage. JFPH report data to the Victorian Healthcare Associated Infection Surveillance Coordinating Centre (VICNISS) and report data to the Australian Council on Healthcare Standards for indicator benchmarking. JFPH have a 'COVID Safe Plan'. There are policies and procedures that guide staff in Antimicrobial Stewardship (AMS).

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
There is a JFPH Infection Prevention and Control (IPC) and AMS Committees that are multidisciplinary. They have Terms of Reference (TOR) that clearly describe their responsibilities of monitoring and improving IPC by monitoring data, ensuring training and having action plans in place for risks identified. There is a Healthscope Pandemic and Outbreak Management Plan in place. Infection Control indicators are reported to the Healthscope Board.

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
Through the JFPH contract with HICMR there is a comprehensive schedule of auditing for IPC systems. Any areas that do not reach the required targets have an action plan created that includes reauditing. AMS is discussed at relevant committees, i.e. Medical Advisory Group (MAC) and the AMS Committee and discussions are held and documented to improve performance where gaps are identified. Healthscope has National Standards Committees and Infection Control and AMS data is reported to these committees as well as the Board. There are risk assessments against infection prevention and control and associated action plans.

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
Patients and staff interviewed at JFPH by members of the assessment team were able to confirm that staff actively clean their hands, and they were informed about issues relating to IPC and AMS measures. Information is available for patients, carers and families that has been reviewed by consumer consultants. Patients, carers and families confirmed that they are actively involved in the treatment process through shared decision making. Medical record documentation shows evidence of patient discussion about treatment decisions, including the use of antimicrobials.

Rating	Applicable HSF IDs
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
JFPH monitors and collects data on healthcare related infections and antimicrobial use as well as several other areas of infection control surveillance. JFPH reports to VICNISS on areas such as SABS, CDI, BBFIs. Results demonstrate the following: 2023/2024 Q3: • 1 SAB 0.6. • Peripheral Central Venous Catheter, 2, 0.05% • SSI, 1, 0.02% • CLABSI, 0. • HAI – 0.26% (0.35% target) Staff were noted for assessing patients on admission in relation to infection prevention and control, i.e. recent travel overseas. Data is provided to clinicians and each of the units at JFPH.

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
At JFPH a review of the infection control documents and the HICMR resource site indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare (AGPCIHC) for standard and transmission-based precautions are in place. There is signage in place as required and other resources were consistent with the AGPCIHC. JFPH uses signage from the Australian Commission on Safety and Quality in Healthcare resources. JFPH has created transmission 'boxes' that include signage and other resources required to isolate and identify transmission precautions.

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
JFPH have policies and procedures in place for the management of organism-specific risks. JFPH processes are consistent with Victorian and Public Health advice. Handover, transfer of care and discharge processes include the requirement for documentation and handover of infection status. Patient information, for example 'Infection Prevention and Control' brochure for patients and visitors and preadmission processes are utilised to advise patients, carers and visitors on infection control and management processes in place. Stickers to advise of transmission risk are utilised in the Medical Record. There is COVID Screening and a process to note if the patient has had COVID in the last 28 days along with checks for overseas visitors. Fit testing compliance – target is 90%, currently due to a lack of trainers in fit testing, compliance is sitting at 55%. High Risk areas 72%. All patients who present to the Emergency Department are RAT tested and they are asked about their vaccination status. All patients transferred to the Rehabilitation facilities have a further assessment before they leave. Training in IPC is sitting at 70%.

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
JFPH has procedures available for implementing standard and transmission-based precautions (S&TBPs) and all staff (including non-clinical staff) are provided with education appropriate to their role. Policy: Standard and Transmission Based Precautions – 15.03. Staff were able to confirm their use and understanding of these measures and risk screening procedures i.e. at admission for overseas travel and other infection alerts.

There are environmental management and cleaning practices in place, and these are consistent with JFPH policies. Various areas have appropriate environmental cleaning audits in place. The auditing system 'MATS' is used to record several of the audit results. The old building design does present challenges to the hospital. Risk Assessments – Audit of the Quality of Cleaning – due to the poor results in the Emergency Department, processes to improve the cleaning including high touch areas has seen the results go from 60% to 80%. Most areas result average at 90%. Any identified areas of concern identified at audit are rectified immediately.

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
Patient infections/status is included at all transfer of care / handover points and compliance is monitored. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry of patient rooms. Depending on the infection, the following strategies may be used: limiting visitors, (two visitors, named at reception) education for visitors, education on donning and doffing and compliance with hand washing and instructions to leave the hospital directly following a visit. There are also patient information/brochures available.

Rating	Applicable HSF IDs
Met	All

ACTION 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Comments
The JFPH hand hygiene (HH) program is consistent with the current National Hand Hygiene Initiative (NHHI) and Victorian requirements. There are auditors in place who undertake regular compliance and observational audits. Current compliance rates are 92%. Current HH training compliance rate is 95%. There was a good distribution of HH products for use by staff, patients and visitors with the number of dispensers recently increased.

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
JFPH has policies and procedures in place for 'Aseptic Technique' (AT). Staff are appropriately trained, and competency/compliance is monitored. Training theory has recently been completed; therefore, compliance is 69% as staff complete the new training. Practical competencies 91%.

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
JFPH has training and assessment for the management of invasive medical devices (IMDs) available to staff and align with current best practice. There is a 'Peripheral Intravenous Catheter' (PIVC) chart. A gap analysis was completed on the Management of PIVC Clinical Care Standard. Staff receiving education on cannulation receive best practice training. Auditing has highlighted the need for further education on 48-hour post removal inspections. HAI 0.26% (target is 0.35%).

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
JFPH has cleaning procedures and schedules in place with regular auditing and reports made available through the governance structures. Cleaning standards consistently meet targets, and any remedial actions are implemented immediately. There are Material Data Sheets (MSDSs) available and are checked as part of the audit process. Chemical training is provided through Ecolab and current Ecolab Safe Chemical Handling is at 78%. Chemical spill kits are found in the relevant areas. There is a register of chemicals. Staff were able to outline the procedures in the event of an outbreak situation and novel infections.

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
JFPH as part of Healthscope has IPC processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that is responsive to novel infection risks and pandemic planning. Healthscope have developed a process for all new products that are reviewed and trialled, assessed for infection related risks. There is a preventative maintenance program and a response process to equipment failure. JFPH has recently participated in one of the trials related to a reusable torniquet.

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
JFPH has a comprehensive workforce immunisation program in place that complies with the Victorian policy and national guidelines. There is a program that offers influenza vaccinations at JFPH. Current influenza vaccination rate is 81% (period not complete). JFPH report influenza vaccination rates to VICNISS. The following policies are in place: •   Blood testing (Health Care Workers) for blood borne diseases •   Covid 19 vaccination policy – accredited practitioners •   Covid 19 Vaccination Policy – Workers •   Immunisation for Vaccine Preventable Diseases for HCW. Staff working in JFPH 'High risk areas' have additional vaccinations.

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 is an annual influenza vaccination program vaccination in place that will conclude at the end of August. 100% of the workforce are fully vaccinated for COVID-19. There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. Records of workplace allocation include both appointed and locum staff. The program for workforce screening and workplace exclusion is aligned with (Victorian) Health Directions. A tiered approach to outbreak and pandemic planning and management is in place. As mentioned in action 3.15, the following policies are in place: •   Blood testing (Health Care Workers) for blood borne diseases •   COVID 19 vaccination policy – accredited practitioners •   COVID 19 Vaccination Policy – Workers •   Immunisation for Vaccine Preventable Diseases for HCW.

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
A review of JFPH documentation demonstrates that processes are in place for quality management of reprocessing reusable equipment, instruments and devices. A gap analysis has been completed on the Australian Commission on Safety and Quality in Health Care (ACSQHC) advisory AS18/07 regarding compliance to AS4187. JFPH has already completed a gap analysis of its compliance with AS 5369:2023. All policies and procedures have been updated to reflect the new AS5369-2023. 91% of staff are competent in CSSD competencies. Sterile stock audit in June 2024 100% compliant. Meeting with staff involved in reprocessing reusable medical devices (RMDs) confirmed that relevant national standards are followed. Assessors observed that facilities, equipment and sterile stock storage were compliant with the requirements of the ACSQHC Advisory AS18/07. JFPH has an instrument tracking system in place. Sterile Stock tracking audit conducted in December 2023 was 100% compliant. There is a gap analysis for the Flexible Endoscopes Toolkit (5369). JFPH is currently relocating the endoscopy cleaning system from the endoscopy procedural room to the CSSD. This will ensure that all procedures are compliant. Ultrasound probes 5369 gap analysis has seen the implementation of the UVL Antigermix processor.

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
JFPH has a policy in place that governs the antimicrobial stewardship (AMS) program. Terms of Reference govern the function of the AMS program. Membership of the committee includes the Director of Nursing (DON), Infection Control Coordinator (ICC), HICMR Consultant, Infectious Disease Physician (IDP), AMS Clinical Pharmacist, ICU Consultant, ICU NUM, ED Consultant, ED NUM, Oncology NUM and a Quality Representative. There is a list of restricted antimicrobials and an approval process. A gap analysis has been conducted on the AMS Clinical Care Standard. There is the 'Antimicrobial Prescribing and Management' Policy. Antimicrobial usage reports are available detailing use of restricted antimicrobials and compliance to Policy. These reports are reported quarterly to the AMS Committee. Compliance is monitored through NAPS and the Pharmacy Department. Clinical staff have received education on their responsibilities for AMS prescribing. JFPH while their program is in its infancy complies with the requirements of Advisory 18/08 and ACSQHC Fact Sheet 11 (3.15d).

Rating	Applicable HSF IDs
Met	All

ACTION 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Comments
There is an overarching AMS program at JFPH that includes policies and procedures. JFPH uses a Traffic Light Formulary system to identify the various risk levels of antibiotics and has a review system in place for high-risk antibiotic ordering. JFPH, since the beginning of the year, has a weekly visit from an IDP who reviews the current orders in partnership with the Clinical Pharmacist. JFPH monitors its performance by participating in the National Antimicrobial Prescribing Survey (NAPS) and has also started surveillance through the National Antimicrobial Utilisation Surveillance Program (NAUSP). Clinicians were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing.

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
There is an appropriate governance structure in place across JFPH with an active Medication Safety Committee which reports to the Quality Committee and the Patient Care Review Committee. There is appropriate policies and procedures in place which is supported by active education programs for prescribers and consumers. Staff have allocated time to complete mandatory MED+SAFE training and this is currently sitting at 87%. The governance of medication utilisation is supported by traffic light systems formulary for APINCH (high risk medication and AMS prescribing). JFPH have a great professional partnership to the outsourced service of HPS. This service provides the hospital with clinical pharmacists (who provide recording of a Best Possible Medication History (BPMH) on admission for all patients, followed by a medication reconciliation again for all patients prior to discharge, as well as patient education and a supply of consumer medication information (CMI) sheets and a revised medication list at the time of discharge. The Clinical Pharmacists work with VMOs to provide an appropriate AMS service in liaison with an Infectious Diseases Physician. The Pharmacy team are a great asset for JFPH and are very dedicated to ensuring Medication Safety within the hospital. They also play a very critical role in the production of Chemotherapeutic infusions for Oncology and Haematology patients in a purpose-built facility in an adjoining building. The many years of experience in this service, is also developing an ongoing future team of dedicated Pharmacists to continue this highly tailored and meticulously conducted service for patients in the future.

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
JFPH regularly monitors the effectiveness and performance of the medication management system through reporting of a range of audit and performance indicators. The regular audits include medication related clinical incidents, medication storage, security, checking and documentation of both S8 and S4R medications. Incidents reported through RiskMan are used to identify any developing themes and identification of alignment with the 'Seven Rights' of medication safety. JFPH have an 'Incident Reflection Tool' which staff are required to complete following a clinical incident and the 'learnings' are shared across the whole hospital as well as with Healthscope.

High risk medications are appropriately labelled and stored separately and the principles of Medication Safety such as tall-man lettering, line labelling and the use of Ambulance Retrieval Victoria medication infusion guidelines reduces the likelihood of potential medication errors as well as compliance with the Seven Right's for medication safety. Where these audits identify an area for improvement, the changes are implemented, and future audits are used to demonstrate whether they have been successful. Staff are provided with information related to lessons learned and audit results. |

Rating	Applicable HSF IDs
Met	All

ACTION 4.03
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
The consumer is at the heart of JFPH medication safety policy. Consent is central to this process and is always gathered. All consumers have a right to a second opinion. Patient medicines information leaflets are available and are supplied by HPS Pharmacy and/or through the printing of Consumer Medication Information (CMIs) sheets. All inpatients are reviewed by the treating Specialist who explains to the patient why the drug is required and to reinforce the need for the patient to continue with the treatment. As stated earlier, the Pharmacy staff then conduct education for both the patient and/or their family/carer at the time of discharge. Assessors observed this education being provided and the questions asked by the patient/family/carer in response to the education provided. This was observed to be a well needed and provided service to consumers of the service.

Rating	Applicable HSF IDs
Met	All

ACTION 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Comments
The thorough credentialing processes at JFPH ensures that only doctors can prescribe medications within the hospital. Annual AHPRA checks are conducted to ensure there are no limitations on prescribers. In addition, prescriptions will not be dispensed without the doctor's prescriber number and signature check. There is a hospital formulary which guides prescribing and dispensing. The HPS Pharmacy has an active audit program to support this for JFPH. There are no Nurse Practitioners at JFPH, so nurses can only administer medications, not prescribe.

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
In most hospitals it is the responsibility of the admitting doctor to complete the BPMH and this ideally would be conducted within hours of the admission of a patient to the hospital. Due to the private structure of this hospital, there are not any junior doctors who can perform this duty and therefore HPS has been employed to provide Clinical Pharmacists to complete this role. JFPH has three clinical pharmacists on staff and as stated in 4.01, they perform a BPMH for all patients soon after admission and this is documented in the patient's medical record HMR 4.5. Out of normal hours, there is an HMO that works exclusively in ICU that can perform this function or else there is an on-call Pharmacist 24 hours a day who can come into to perform this function. The BPMH is obtained by the Clinical Pharmacist from at least three sources: the patient's own medications, previous hospital admission, the patient's GP or local Pharmacist.

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
The role of the clinical pharmacist extends from the recording of a BPMH in the patient's medical history to reconciling each patient's medications in line with any new medications ordered by the treating doctor. By the time of discharge, the clinical pharmacist will have reconciled the discharge medications with the final medication sheet.

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
All Adverse Drug Reactions (ADRs) are recorded on admission as part of the BPMH by the clinical pharmacist and this is also communicated to the nursing staff if they have not already picked this up. It is also recorded on the medication chart as well as the alerts tab in WebPAS. The patient is provided with a 'Red ID bracelet' to indicate they have an allergy, ADR or some other kind of alert that staff should be familiar with. This was confirmed by Assessors during discussions with patients who could articulate why they required a red ID bracelet.

Rating	Applicable HSF IDs
Met	All

ACTION 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Comments
All ADRs are recorded in the clinical record, on the medication chart, Anaesthetic chart, IV order sheet and also in WebPAS by the Registered Nurses and Clinical Pharmacists. Pharmacy note any ADRs and report to the TGA if this has occurred for the first time. A new ADR is also recorded in RiskMan.

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
As stated in 4.08, Pharmacy note any ADRs and report to the TGA if this has occurred for the first time and also in the patient's medical record. A new ADR is also recorded in RiskMan.

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
All patients are stratified based on their clinical risk based on several clinical factors such as their age >65, any ADRs, those on more than 5 medications, multiple comorbidities, a history of poor compliance, or prescribed high risk medications. This function is carried out by the nursing staff at the time of admission to the ward and reported to the ward's clinical pharmacist for priority attention.

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
Informed consent processes are in place to ensure that patients receive the information required to consent to their medication. This is key function of both the Medical Officer (prescriber) and the Clinical Pharmacist (BPMH and medication reconciliation). There is also patient medication education material available through the HPS Pharmacy. This information is regularly reviewed and updated on the Consumer Medication Information (CMI) and HPS sites.

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
Current medication lists are provided as part of the discharge summary as well as the reasons for any changes to this list. A current prescribing list is always maintained and is provided to any receiving clinician at any transition of care. The patient is provided with a list of current medications as well as the reason for any changes at the time of discharge and the assessors viewed many of these lists which were very comprehensive and informative.

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
Healthscope and HPS Pharmacy provides extensive clinical information to inform clinical prescribers. The VMOs have access multiple sources of information ranging from local protocols to international resources. Resources include "Don't rush to crush", MIMS, TGA guidelines, Australian Injectable Drugs Handbook 9th Edition etc. For antimicrobials, there is a traffic light formulary developed by the IDP where the RED categories (high risk of resistance antimicrobials) cannot be dispensed without the approval of an IDP.

Rating	Applicable HSF IDs
Met	All

ACTION 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
Comments
The JFPH wards both have a 'Medication Room' which is only accessible via swipe access. These rooms deliver safe secure storage of all manner of medications ranging from over-the-counter medications to S3, S4, S4R and S8 medications in appropriately locked areas/safes. Medication fridges are centrally monitored, and any significant temperature variations are notified to Building Management to enable timely corrective action. The cold chain management is provided by the medication supplier. They have well established procedures to handle the disposal of unused, unwanted or expired medicines. The pharmacists have imprest systems to always ensure a constant supply of in-date medications. There is also a designated area to store any patient's own medications during their stay within the facility and this cupboard is next to the patient's bed. During the assessment it was noted that the nursing staff kept the key to these drawers on them so they could be accessed when required, especially for PRN doses. However, on further questioning, it was found that nursing staff took these keys home each day and brought them back for the next shift. This was reported to the Executive who were unaware of this occurring and undertook an immediate investigation and found this was occurring in some wards. Immediate action was taken to address this identified issue, and the assessment team were provided with the action plan being implemented. The organisation put out a direction that no patient medication drawer keys were to leave the hospital, and they implemented immediately a process where they collected all the current keys, determined the appropriate number of keys required for each ward/department and then implemented a system for assigning and collecting keys from nursing staff at the start/end of each shift. This immediate action prevented the assessment team having to write a recommendation to that effect.

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
Suggestion(s) for Improvement
Continue to monitor that this new process is strictly adhered to following implementation.

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
JFPH has a Victorian Poison's Licence, Secure Safes for S4R and S8 medications, and temperature-controlled fridges for temperature sensitive medications and vaccines. There is also a high-risk medicines policy for APINCH products covering antimicrobials, potassium and other electrolytes, insulins, narcotics (opioids) and other sedatives and short-term anaesthetics, chemotherapeutic agents and heparin and other anticoagulants, which covers storage, prescribing, dispensing and the administration of these products. S8 medication safes have restricted access for appropriate staff only (RNs, MOs and Clinical Pharmacists). Hydromorphone is stored in a separate safe to Morphine due to lessons learned from other facilities. There is no Potassium Chloride in ampoules, and it only comes pre-mixed with 10mmol/100ml in Saline in a pink coloured plastic cover to identify it as high risk.

There is a vaccine fridge in ICU which is checked twice daily and has back-to-base monitoring and the Infection Control Consultant is available for Cold Chain breach incidents. High risk medications are managed extremely well. 'Runbuckets' are available for the disposal of any unused, unwanted, or expired high-risk medications in medication room. |

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
Healthscope Corporate policies and procedures demonstrated the processes that are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. Staff are introduced to these processes at orientation and via ongoing education. A suite of JFPH policies is also in use and staff can access all policies and procedures through HINT via the Intranet. There is yearly education calendar displayed on the ward/Unit Quality Boards for education delivered at Lunch and Learn sessions and education also was also observed at handovers attended by the assessors. Managers are responsible with the support from educators to implement any new policies and procedures.   The Daily Comprehensive Care plan used shift to shift evidenced the clinical risk assessments. Observation and a review of clinical documentation confirms that processes are in place for managing risks associated with comprehensive care. Over 77% of eligible staff have completed education on various comprehensive care topics; 85% completed Relationship Centred Caring and 78% Pressure Injury Prevention, with continued monitoring for compliance.

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 by regular audits, that are documented benchmarked within the organisation. A good example of a quality improvement is the Hover Jack Met Call ensuring review of all post fall patients by medical staff and reducing manual handling incidents. The organisation uses feedback, data and outcomes together with evidenced based practice to support improvements in care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. Patients interviewed on various wards spoke highly of their care and all demonstrated an excellent understanding of all aspects of care including ongoing care post discharge.

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. Processes are in place to partner with patients in their care. These include involving patient, family and carer input at handover and reviewing goals of care in conjunction with the patient. The patient care boards, and handover ensure currency of information regarding goal setting, care pathway, identification of risks and identifying the VMO and staff responsible for accountability during the shift. The Hospital Co-coordinator assumes Executive roles after hours with access to executive personnel if required. Shared and single rooms are used to provide patients with an appropriate setting to best meet their clinical needs. Several patients were interviewed, and they reported a good understanding of their progress, and clinical care pathways. JFPH operates within their scope of service to provide care that best meets the patient's needs and the ward and ED staff have good understanding of the processes for referral where needed.

Rating	Applicable HSF IDs
Met	All

ACTION 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Comments
Multidisciplinary care is well established, and the role of team members is well defined and understood by clinicians. Staff from all professional groups and disciplined interviewed by the assessors were able to articulate how multidisciplinary care works across JFPH and assessors observed a positive culture of collaboration between clinical and non-clinical staff.

Rating	Applicable HSF IDs
Met	All

ACTION 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Comments
Clinicians and patients were able to describe how they work collaboratively to plan and deliver comprehensive care. Evidence was found in the medical records and the referral process via WebPAS. Multidisciplinary meeting triage risks and Case Mix meetings occur twice a week and include discharge planning.

Rating	Applicable HSF IDs
Met	All

ACTION 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
Comments
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm commencing at preadmission. The Comprehensive Risk screening Toll HMR 6.13G is used on admission to identify any risks ad assist staff in developing action plans to prevent harm. Clinicians were able to describe the risk assessment process and evidence was sighted in clinical documentation. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. Comprehensive Care Audit results for several wards/units for Q2 2024 were above 90% compliance and areas of poor compliance are to receive education and will be reaudited. The organisation is compliant with the requirements of Advisory AS18/14.

Rating	Applicable HSF IDs
Met	All

ACTION 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Comments
JFPH has processes in place for identifying First Nation's patients and recording this information in administrative and clinical information systems on admission. Documentation is done in WebPAS and on all administrative and clinical documentation. This is audited, and only 0.3 % of admissions identified as First Nation's People. Staff were able to describe the processes in place and 85% of eligible staff have completed the 'Cultural Diversity and Sensitivity in Health Care' training.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09
Patients are supported to document clear advance care plans
Comments
Healthscope Corporate has policies in place to assist with advanced care planning. All patients are screened on admission, and it is documented on the Alerts sheet HMR 000 in the medical record if completed. 100% of eligible staff have completed 'Asking the Question' education. Information and resources are available to support and assist patients to document advanced care plans in conjunction with medical staff.

Rating	Applicable HSF IDs
Met	All

ACTION 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Comments
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated including in Recovery prior to discharge into the ward. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound risk. A social history is also undertaken and reviewed during discharge planning. Risk screening processes are subject to audit and reports are provided through the organisation's governance structure. The assessors reviewed medical records and observed clinical practice to confirm compliance with the screening process, however some staff were unsure of the risk screening requirements for the 4AT now that only one risk was required. An action plan and education were commenced during the assessment. JFPH is compliant 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
Clinicians were able to articulate the comprehensive assessment required and the interventions and referral process for risks identified. Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Clinical Risks are reassessed every seven days or if a patient's condition changes. Formal audits and the review of documentation at the bedside handover ensures risk screening is effective.

Rating	Applicable HSF IDs
Met	All

ACTION 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Comments
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk. Alerts are documented on the Alert Sheet HMR000, on patient care boards, yellow allergy stickers on medical record notes and patients wear a red arm band.

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 review of clinical documentation by the assessors confirmed that patient-specific health issues and risks are identified, documented, and communicated effectively to ensure appropriate care. Discharge planning is initiated on presentation to the hospital. Referral to the discharge planners via WebPAS contributes to effective discharge planning. The process is effective in accessing other services, for example ACAT, rehabilitation and a range of community care services including the JFPH HITH team. The assessors witnessed interactions between clinicians, patients and families which confirmed partnership in care and decision-making. Care protocols are aligned with evidence- based best practice. The requirements of Advisory AS18/15 have been met.

Rating	Applicable HSF IDs
Met	All

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

Rating	Applicable HSF IDs
Met	All

ACTION 5.15
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Comments
Processes to define those patients at end-of-life are in place and staff interviewed were aware of these. The organisation has aligned is processes to the National Consensus Statement: Essential elements or safe and high-quality end-of-life care.

Rating	Applicable HSF IDs
Met	All

Org Name   :   John Fawkner Private Hospital
Org Code   :   220189

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
JFPH has access to Oncologists and Palliative care physicians through the Oncology ward and referral system on WebPAS. Community palliative care services are available from Northern Health. Melbourne Health, and Home Care services. JFPH has an excellent relationship with local Aged Care facilities who can provide care for those families who are unable to provide required care at home. Graduate Nurses undertake a rigorous education program for End-of-Life Care. There is an End-of-Life pathway and the End-of-Life Tool Kit resources from Safer Care Victoria (SCV) is available through the Intranet.

Rating	Applicable HSF IDs
Met	All

ACTION 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Comments
A review of clinical documentation confirmed that if a patient has an advance care plans it is documented in three separate areas in the patient's healthcare record. Clinicians interviewed were able to describe the process in place to ensure that patients with an advance care plan are identified, and that care is provided in accordance with these plans.

Rating	Applicable HSF IDs
Met	All

ACTION 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Comments
Supervision and support for staff providing end-of-life care are available through and staff are aware of how to access support services. A review of clinical documentation confirmed that advance care plans are documented in the patient's healthcare record with compliance at 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Comments
Goals of care for patients at end-of-life are 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 clinical record.

Rating	Applicable HSF IDs
Met	All

ACTION 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Comments
The organisation supports shared decision making about end-of-life care with patients, their carers and families. This is supported by regular communication and documented in the clinical record, and the assessors saw evidence of this in clinical documentation. Support for decision making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Families are offered support through Grief Australia Crisis Support or local chaplaincy.

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
Healthscope Corporate has evidence-based policies for pressure injury prevention and wound management. These are well referenced and reviewed. No hospital acquired pressure-injuries were reported over the past six months.

Rating	Applicable HSF IDs
Met	All

ACTION 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
Comments
Skin assessments are done using a modified Waterlow Chart on admission and photos (with documented consent from the patient) of any wounds are recorded in the medical record with referral to a Wound Care Nurse. Skin inspections are conducted in accordance with policy and compliance is reported through the Comprehensive Care Audit. Risk is reviewed at every shift change / or in the patient's condition.

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
A Healthscope Prevention of Pressure injuries brochures is available for patients and families, and this has a consumer approved stamp and is in a user-friendly format. Equipment products and devices, including air mattresses and memory foam cushions are used to mitigate the risk of pressure injuries and are readily available for staff to access. Discharge summaries reference risks and importance of position changes.

Rating	Applicable HSF IDs
Met	All

ACTION 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Comments
Healthscope Corporate has policies in place for Falls Prevention and JFPH manage education for staff, including April Falls Week with a focus on risk factors and recent trends. Compliance with undertaking falls risk assessments and falls management action plans has improved since the introduction of the protocol in May 2024 of calling a Hover Jack Met call for all patient falls. This ensures all patients are reviewed by a physician and a Post Fall Huddle is completed. Risk is redone and referral to a physio completed. Incident data related to falls is analysed and reported through the organisation's governance structure and actions are in place to improve the outcomes. Currently JFPH results of 0.29% are trending downwards from the Q3 2023 result of 0.36% and Q4 2023 result of 0.32%.

Rating	Applicable HSF IDs
Met	All

ACTION 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
Comments
Equipment, devices, and strategies to prevent falls and minimise harm from falls are available to staff. The physiotherapy service provides guidance and assistance with mobility aids and individualised patient plans. Each Department/Unit has appropriate equipment such as Sara Steady, alarmed fall mats and lifting machines available for use.

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
A JFPH information brochure is available to patients, their carers / families about falls prevention and risk management strategies and this information is in a user-friendly format.

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
Patients are assessed for nutritional needs and risk of malnutrition on admission/change of care needs. Referral to a dietician is done through WebPAS. Special dietary plans developed by the dietician are coded into WebPAS and this is communicated through ChefMax which is used by catering staff.

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
JFPH has a kitchen on site and a menu monitor also visits patients several times a day. Meals arriving on the ward are checked by the nurse in charge before delivery. Red trays are used to notify of a patients need for assistance with eating and drinking. Nutritional support is provided to patients based on their specific needs, identified through risk screening. A dietitian referral is done through WebPAS for those patients identified as at risk or with specific needs. Food and fluid intake is monitored and reported.

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
Cognition screening is undertaken on admission and as required throughout a patient's admission where clinically indicated. Evidence based policies and procedures support staff in developing appropriate management / care plans and these strategies are reviewed for effectiveness. This includes the use and monitoring of medications to ensure compliance with best-practice standards. Staff are aware of other forms of treatments that can be put in place to avoid the need to restrain. Chemical restraint if used, cannot be implemented without authorisation from the treating VMO and Consultation with family/carer. The use of antipsychotics and other psychoactive medicines is in accordance with best practice and legislation. JFPH is compliant with the requirements of Advisory 18/12 (1.27b) and ACSQHC Fact Sheet 11 (5.29a).

Rating	Applicable HSF IDs
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
Documentation reviewed shows systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken. Staff were able to describe how the collaborate with patients, carers and families in caring for patients with cognitive impairment. The Sunflower tool is available in the Standard 5 resources folder and online. A Cognitive Impairment brochure and a Family/Carer consultation brochure are available to staff on HINT and referrals to a Geriatrician are done through WebPAS.

Rating	Applicable HSF IDs
Met	All

ACTION 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Comments
Strategies and screening tools are in place on admission and during the continuum of care identifies patients at risk of self-harm and / or suicide. On identification of patients who may be at risk transfer to a more appropriate facility is organised. JFPH has several staff who have completed their Mental Health First Aiders Course. There is a Suicide Assessment and Disposition of Patients suspected to be at Risk, form JP4.63 and for patients triaged in ED as ATS Cat 2 /ATS Cat 3 – a Medical and Mental state assessment is completed. Mental Health Escalation Plan and documented intervention strategies. Staff have access to Emergency Mental Health Services(EMHS) based on the patients address.

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
Where patients have self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and referral service to other Healthscope Hospitals or local Public Mental Health Facilities where patients are identified as at risk. Patients who are deemed at risk of physical harm to self or others are not admitted to JFPH.

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
The organisation has policies that support the identification, mitigation and management of aggression and the HITH staff complete their own home assessment on admission to the service. They also carry an alarm and phone.

82% of Staff have completed WAVE training and staff interviewed had a good understanding of de-escalation strategies, with support for security services, orderlies or police. Training is implemented at orientation and annually thereafter. Code Black is used, and incidents of aggression are infrequent and reported through the JFPH governance structure. |

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	
JFPH has strategies and processes in place for staff to identify patient triggers and dependency that may precipitate aggressive behaviour. There is a Healthscope Corporate policy 2.54, Self-Harm and suicide (threatened, attempt or completed) in non-mental Health Facility and Patient Centred Model of Care has been implemented. Staff are made aware of the importance of body language and strategies to de-escalate and OVA practical training for staff to attend has been booked. The processes to manage aggression aims to minimise harm to patients, carers, families, staff and visitors. Staff were able to describe how to call a Code Black and ring triple 0 (000) for support and arrange a hospital transfer.	
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	
Restrictive practices-Pt Restraint (non-Mental Health Facilities) Corporate Policy and Procedure 8.95, governs the use of both physical and chemical restraint and is consistent with legislation. Alternative strategies are routinely implemented, and use of inappropriate restraint would be found through audit or Pharmacy. A risk benefit/analysis is documented in medical record when a restraint is authorised, and the patient is to be observed at all times. Restraint authorisation is compliant with the Victorian State Legislation.	
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
Seclusion is not used by JFPH as it is not a gazetted organisation.

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
JFPH has policies and procedures in place to support effective communication including handover. They have a Communicating for Safety Committee in place that reports to the Quality Committee and to the Patient Care Review Committee. They utilise the ISBAR process when handing over and processes are in place for 'Time-Out'. Bedside handover training is in place with 94% compliance. The assessor viewed documentation and was able to see clinical communication at handover in place, and staff were able to describe the processes. JFPH has identified risks involved in communication and have controls in place.

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
At JFPH incidents relating to failures in clinical communication are reported through RiskMan. The effectiveness of the systems is monitored through the following audits: •   Theatre Time out Audit – Operating Theatres •   Clinical Handover Audit – Acute Wards Results from audits drive improvement and change as required in communication and is monitored via the Communicating for Safety Committee.

Rating	Applicable HSF IDs
Met	All

ACTION 6.03
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
JFPH has policies and procedures in place that ensures the engagement of patients, their carers and families in their own care and shared decision making. Staff at JFPH staff were able to describe instances where the patient and family are involved in making decisions regarding ongoing care and treatment following discharge. This included a Multidisciplinary Team (MDT) approach as part of the assessment process. Discussions with patients at JFPH reported being engaged in their care and they have the information available to make informed decisions about their care.

Rating	Applicable HSF IDs
Met	All

ACTION 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Comments
JFPH has policies in place that support appropriate identifiers are used in procedure matching, transfer of care, handover, discharge and where changes in clinical care patient risk profile are identified. For example, the assessor viewed a transfer of care and identification for a patient being transferred to the radiology department for a radiology procedure. Documentation supported the use of specified identifier in various situations.

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
JFPH has policies and procedures that defines the use of three approved identifiers according to best-practice guidelines. Assessors viewed clinical handovers and staff interviewed were able to describe how and when these are used. Patients were aware of the process of using three identifiers when care was handed over and participated in the process. It was also noted in theatre and when attending a radiology procedure.

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
JFHS demonstrated to the assessors the use of approved patient identifiers as outlined in Action 6.5. There are also processes in place for surgical / procedural time-out and this is documented and audited. Documentation reviewed supported these findings, such as the surgical 'time-out'.

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
JFPH staff were able to demonstrate that accurate and relevant information about a patient's care is communicated and transferred at every clinical handover. Compliance is audited and reported. Staff were able to describe their respective roles in clinical handover and time-out processes, including the minimum information to be communicated. Observation of several handovers identified that time-out was observed.

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
At JFPH the team of assessors witnessed clinical handover that was structured. The ISBAR tool was utilised for clinical handover relevant to the situation. Patients were effectively engaged with the patients and carers. Each patient has a defined goal of care that is documented and placed on the Patient Care Board. The processes in place for clinical handover ensure relevant clinicians are actively engaged in the process and members of the multidisciplinary team are utilised and involved as required. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learn shared and disseminated.

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
JFPH has processes in place to communicate critical information including risks and alerts. This includes the use of an alerts form and entering of alert information into the patient management system. Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately. Staff have access to critical information required to provide effective care. The patients are involved in shared decision making that supports the communication of critical information to support clinical and patient decisions.

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
JFPH were able to demonstrate communication processes for patients, carers and families to communicate critical information and risks about care to clinicians. The assessor was able to observe the process of communicating critical information and risks.

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
At the commencement of each shift, each ward conducts a safety briefing to identify any safety issues either within the work environment or with patients. Clinical documentation demonstrated that critical information, alerts and risks are documented, and this included the patient information system (Alerts only). There is training in the area of Nursing Discharge Summary and audits in the areas of clinical handover, time out in the procedure room, theatre time out audit, Double UR number audit and Improving patient identification on admission reducing double UR's.

ISBAR is used to handover information, including a lanyard prompt card. Patient Care Boards are updated each shift to reflect changes in patient goals and care. |

Rating	Applicable HSF IDs
Met	All

Standard 7 - Blood Management

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

ACTION 7.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Comments
A suite of Healthscope Corporate Policies is in place for blood management and the management of associated risks. The Policies align with National Evidence based guidelines and professional bodies but not limited to: • National Blood Authority • Australian Red Cross Life Blood • Australia New Zealand Society of Blood Transfusion (ANZSBT) Staff who administer blood are compliant with the Healthscope BloodSafe Training and overall compliance is currently 76%. Competencies are done yearly and overseen by managers and educators.

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. Strategies for improvement include ongoing education for medical and nursing staff. Audit results from the completed Appropriate Use of Blood Products in Q1 2024 and Q2 2024, resulted in a Lunch and Learn education for Transfusion Procedures, and the Blood Resource pack being updated and made readily available for staff. A quality Project to improve the Informed Consent Process was taken to the MAC, and independent checking and two signature signing on the transfusion form has been introduced. Reports are provided to the Blood Management Committee who meet quarterly and reported through the governance structure.

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. A patient who received blood was interviewed and confirmed their engagement in informed consent.

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 organisations processes and policies support the clinically effective and efficient use of blood and blood products. Pre-transfusion checks are utilised to minimise wastage and the inappropriate use of blood and blood products. Cell Savers are available at the request of the surgeon. The current audit tool for' Inappropriate use of Blood and Blood Products' is under review. Physicians will review appropriateness of transfusion and alternative treatments or courses of action undertaken if appropriate.

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. Compliance is audited and referred to the MAC if applicable.

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 and procedures 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. Incidents are cross referenced with Australian Clinical Labs (ACL) to ensure accuracy of data. Outcomes are discussed at the Blood Management Committee and the MAC.

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 reporting of adverse events related to transfusions. These are monitored and reported through the Blood Management Committee and appropriate action taken.

Rating	Applicable HSF IDs
Met	All

ACTION 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Comments
The organisation contributes to haemovigilance activities including reporting ACHS Indicators to the National Blood Management Committee and benchmarks against other Healthscope Hospitals.

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
Blood and blood products are stored, distributed and managed in compliance with legislative and regulatory requirements and can be traced at every point of transition. ACL report on usage and details can be tracked through the patient management system. Blood is Stored in a Blood fridge that is monitored by ACL. Processes are monitored and reported through the Blood Management Committee. Any incidents related to inappropriate handling of blood or blood products are reported and managed through the incident management system.

Rating	Applicable HSF IDs
Met	All

ACTION 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Comments
Processes are in place to manage the availability of blood and blood products, eliminate wastage and respond to shortages. The use of blood and blood products is monitored and reported through governance reporting mechanisms. ACL can send/receive blood resources to/from other sites to eliminate avoidable waste and receive supply if required.

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
Healthscope Corporate policies and procedures are in place for recognising and responding to acute deterioration. Staff can access them through the intranet (HINT). Orientation includes education on recognising and responding to physical and mental deterioration. Ongoing training needs are in place to ensure staff are competent in recognising and responding to clinical deterioration and requirements are managed in line with policies and via mandatory and role required stipulations.

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
JFPH monitors and reports the effectiveness of processes for identifying and managing acute deterioration. This is reported through the quarterly Clinical Deterioration Committee meetings, and to clinicians for the purposes of clinical review. In response to incidents related to clinical deterioration improvements have been made including Hover Jack Met Calls, Met Call Protect (for patients in Infection Prevention Isolation) and educating staff to ensure a culture of reporting. Resuscitation Trolleys in all wards and units are identical. A portable backpack is taken by the ICU Physician when attending a code blue, as it contains additional supplies for advance resuscitation.

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. Patients and families are given an "If you feel Worse" brochures on admission. The posters are also displayed on the wall beside the Care Board and can be used for physical or psychological deterioration. This process includes involving patients, meeting their information needs and shared decision making was observed during bedside handover. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration.

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
At JFPH vital signs are monitored in accordance with the policy 'Recognising and Responding to Acute Deterioration' and recorded on the 'Adult Vital Signs Chart', a track and trigger chart. A review of clinical documentation supported this, and an annual audit is conducted: 'Observation Chart Audit'. Audits demonstrated that MET and Code Blues are activated as per the observations. The chart supports the recognition of deterioration and highlights the need for escalation / intervention. Those interventions are outlined on the chart. There is a Clinical Deterioration Committee in place.

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
There are policies in place for the Identification of patients at risk of harm. Staff were able to articulate the procedure to escalate care. As part of the admission process patients are assessed for cognitive impairment or delirium. Documentation viewed supported that assessments result in individualised and appropriate management plans. These plans are audited via Standard 5, 'Comprehensive Care Audit – Adult'. JFPH has conducted a quality project for AS19/01.

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
JFPH has a Recognising and Responding to Acute Deterioration Committee that reports to the Quality Committee and Patient Care Review Committees. This allows for the monitoring of 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 the Comprehensive Care Audit – Acute and the Observation Chart Audit.

Staff and patients interviewed were aware of processes and were able to describe them and the process to escalate care. The requirements of Advisory AS19/01 have been met. Morbidity and Mortality meetings are held, and data is prepared by the intensive care consultant. Geriatricians are available and Mental Health referral pathways are in place. |

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	
JFPH has processes in place for the patients, carers or families to directly escalate care. There is a 'Rapid Response Systems for Patients, Carers and Families' information for patient and carers. The brochure and posters outline the process that can be instigated by patients and families can complete for a response. Discussion with clinical staff, patients and carers confirmed that processes were in place.	
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	
JFPH has a policy for the escalation of care and supporting tools provide clear direction for staff to escalate care and response to clinical emergencies. Staff are aware of the process, and there were responses during the time the assessors were present at the health service. Several documents were provided to the assessors and the system has a reporting process through the Recognising and Responding to Acute Deterioration Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff at JFPH were able to describe the systems in place to escalate care that is consistent with their policy. Documentation/evidence provided to the team demonstrated that these processes are monitored and reported on, and improvements made to the systems as required.	
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
JFPH educators provide and monitor compliance with training for clinical staff on recognising and responding to clinical deterioration. Track and Trigger Observation Charts which are age appropriate are in use and criteria can be altered for individual needs. Education is provided to clinicians on the use of charts and assessments at orientation and through lessons learned and reflective teaching. Compliance with BLS training is reported as 70%.

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 24/7. Medical and nursing staff in ED and ICU are trained in ALS. RMO provide evidence of training and JFPH train the Trainers complete nursing staff education. ALS compliance is currently at 85% for eligible staff and 100% of ICU In-Charge nurses are ASL competent.

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
Interviews with clinicians confirmed the process for timely referral to an appropriate mental health service that best meet the needs of patients whose mental state has acutely deteriorated. Staff were able to articulate the referral process for these patients. Orientation includes a session on recognising and responding to mental health deterioration, including delirium. The requirements of Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Comments
Policies and procedures are in place for the timely referral to specialist care for patients who physically deteriorate. Transfer to ICU or a larger tertiary hospital occur, and John Cade Acute accepts patients who may require inpatient psychiatric admission. 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 Clinical Deterioration Committee.

Rating	Applicable HSF IDs
Met	All

Recommendations from Previous Assessment

NIL