NSQHS Standards 2nd Edition Assessment Healthscope - Sunnybank Private Hospital 101177

Accreditation Status	*Accredited*
Date(s) of Assessment	*27/08/2024 - 29/08/2024 (Initial)* *13/11/2024 - 13/11/2024 (Final)*
Site	*245 McCullough Street Sunnybank QLD 4129*
Scope of certification	*Acute Services and Dental Services*

Details and Registration of the Health Service
Qld Health Licence QDH1020/79, licensed for 120 beds including 1 Cardiac (Coronary) Care Unit Beds and 5 Intensive Care Unit Beds - expiry: 30/09/2026. *HDAA - Diagnostic Imaging Accreditation Certificate Schedule - Registration No: 2547DIAS expiry: 12/04/2027.* *Food Business Licence (#A006524777) expiry: 01/07/2025.*

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

Contents

ABOUT THE COMMISSION

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

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

THE AHSSQA SCHEME

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

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

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

RATING SCALE DEFINITION

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

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

Suggestions for Improvement

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

Repeat Assessment

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

Safety and Quality Advice Centre and Resources

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

ACCREDITING AGENCY

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

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

Conflicts of Interest

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

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

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

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Sunnybank Private Hospital
The outcome for this assessment is	Accredited
Date of accrediting agency determination	03/12/2024
Date health service organisation notified	03/12/2024
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

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

5.36

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

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

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	Yes A sample was reviewed with evidence of appropriate managment and closure.
Has there been any inspections/audits by regulators?	Yes Private Health Funds 2023 and HICMR August 2023

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements.	Yes
Patient Episode	During the review the assessment team had the opportunity to visit and spend time in the clinical area, observing various aspects of patient care to confirm the adequate provision of information, comprehensive assessment and clinical handover, as well as engaging in discussions with the clinical staff regarding the NSQHSS. · Patient admission UR #328435. · Clinical Handover from operating theatre staff to recovery staff UR #148503 and #12755.	Yes

Requirement	Assessment Outcome	Complies
	· Clinical Handover from stage 1 recovery to stage 2 UR #36473. · Clinical handover from night duty staff to morning staff – Surgical Ward UR #25762, #187945, #316068, #328394 and #328385 and Medical Ward UR #284587, #15251, #328273 and #325216. The Care Boards were updated with the new staff names and goals of care were discussed, evaluated from the previous day and new goals identified in collaboration with the patients for the coming day were also observed during the handover process. · Surgical / procedural time-out with documentation undertaken in the medical records UR #109781 and #328397. · Administration of medication in recovery UR #298042. · Schedule 8 medication administration, surgical ward UR #328387. · Administration of intravenous antibiotics UR #328387. · Insertion of an intravenous cannula UR #328397. · Medication Administration (S8) UR #326373 and #314337. · Infusion commencement UR #325119. · Documentation of patient observations UR #272319. · Medication Management Plan Review by HPS Pharmacy UR #328485. CSSD area was sampled where processes for cleaning of reusable medical devices between patients were observed during the assessment with input from the staff. Endoscope reprocessing of scopes was sampled with relevant staff and microbiological surveillance processes were sighted and were consistent with the facility's policies. Discussion with the Environmental Services Manager and Catering Manager regarding processes surrounding linen, waste, catering services and environmental cleaning services was undertaken. A sample of medical records by the assessment team were reviewed to further verify documentation of processes (n=24).	
Consumer Interview	A number of informal discussions were undertaken with patients throughout the review by the assessment team, including (but not limited to) with four in-patients having morning tea in the hospital gymnasium. All patients expressed positive reports of service provision and staff interactions, including one patient from a culturally and linguistically diverse (CALD) background, who confirmed that the provision of information was sufficient for their needs.	Yes

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Shelley Bustos (Lead Assessor) Initial and Final	Yes	Yes
Dana Rowe (Assessor)	Yes	Yes

Name and Designation	Opening	Closing
Donna Close (Assessor)	Yes	No
Andriy Kurtsen (Acting General Manager /Director of Nursing)	Yes	Yes
Jody Ches (Acting Assistant Director of Nursing)	Yes	Yes
Nyree Luke (Quality and Risk Manager) Initial and Final	Yes	Yes
Ann Knight (National Accreditation Manager)	Yes	Yes
Catherine Cunningham (Director of Finance)	Yes	No
Justine Morrow (National Quality Manager) Initial and Final	Yes	Yes
Nicola Isles (National Infection Prevention and Radiation Safety Manager)	No	Yes
Roisin Dunne (Director of Nursing) Final only	Yes	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	The following high-risk scenarios were tested during the initial assessment with evidence appropriate for scope of services: - Management of patient deterioration - Availability of emergency equipment - Management of IT - Breakdown of reprocessing equipment - Power outage - Agency staff - Management of paediatric patients

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO: - Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	Sunnybank Private Hospital is owned and operated by Healthscope Hospitals, which provides significant corporate support including corporate policies and documents, IT support, incident reporting systems (RiskMan), patient feedback mechanisms, credentialling processes (cGov) and provision of the eLearning platform. Co-located services include diagnostic imaging, pathology and pharmacy.
List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of:	The vast majority of contracts are managed by Healthscope Corporate Services. The main contract managed locally is the contract with Queensland Health Metro South Hospitals and Health Service to admit public patients. The contract is for 12 months and was noted to be effective from 01/07/2024.

- Sterilising - Laundry services - Food preparation - Theatre Services	

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

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Shelley Bustos	A1923	Yes
Auditor	Dana Rowe	A1074	Yes
Auditor	Donna Close	A1011	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

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

Executive Summary

Sunnybank Private Hospital (SPH) is one of the 38 hospitals servicing every state and territory Australia wide managed by Healthscope. There is a corporate Board for Healthscope responsible for strategic governance and leadership as well as an SPH Executive Committee and SPH Medical Advisory Committee responsible for operational governance, leadership and management. SPH is a licensed 120 bed hospital offering a range of medical and surgical services including oncology, day surgery, endoscopy and intensive care specialist as well as inpatient and day rehabilitation services.

SPH was last assessed by the Australian Council on Healthcare Standards (ACHS) on the 15th-17th of June 2021, where two Met with Recommendations were raised and both able to be closed during the assessment conducted by Global-Mark on the 27th-29th of August 2024, however an additional three Met with Recommendations were raised. A final assessment was conducted on the13th of November as required within the 60 business days post assessment period, with all three Met with Recommendations able to be met.

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

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.20	Action not fully implemented	Although Sunnybank Private Hospital has a training program in place that assesses the training needs of the workforce including mandatory requirements, provides access to these training requirements and monitors participation in this program, the completion rates for VMO's is in its infancy and therefore this process is not fully implemented.	Met with Recommendations
3.15	Action not fully implemented	Although Sunnybank Private Hospital has implemented a risk-based workforce vaccine preventable diseases program, the assessors noted that while the VMO vaccinations program has commenced, the process for gathering and recording of VMO vaccinations is not fully implemented.	Met with Recommendations
5.19	Action not fully implemented	Sunnybank Private Hospital has processes for routinely reviewing the safety and quality of end-of-life which have recently been reviewed and a new process commenced but is not fully implemented.	Met with Recommendations

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating

DETAILED REPORT FOR STANDARDS ASSESSED

Action 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance
Evidence Reviewed
Sunnybank Private Hospital (SPH) has an extensive committee structure in place with reporting of safety and quality data evident. The highest level of governance in the organisation is the Healthscope Board and at a local level the Medical Advisory Committee (MAC) is the highest level of clinical governance. Sunnybank Private Hospital has a Clinical Governance Plan 2024-2025 which was approved by the Healthscope Board on the 24th April 2024 and is underpinned by the Sunnybank Private Hospital Quality Plan and the National Quality Plan. Sunnybank Private Hospital committee meeting structure 2024 was reviewed by the assessment team along with terms of reference (TOR) for all committee meetings. The MAC is responsible for monitoring, and reviewing clinical services including credentialing of all Medical Practitioners and the Sunnybank Executive Leadership Team are responsible for overseeing service provision. During the assessment the Sunnybank Private Hospital Organisational chart was reviewed and it was noted to display clear lines of reporting to the General Manager (GM)/Director of Nursing (DON).
Rating
Met
Findings
-

Action 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Evidence Reviewed
Sunnybank Private Hospital uses the Healthscope Reconciliation Action Plan Jan 2024 - Dec 2025 along with the Sunnybank Private Hospitals Indigenous Engagement Plan 2024-2026, as the framework to guide the facility and to deepen their connection to the First Nations communities within their service provision.
Rating
Met
Findings
-

Action 1.03
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
Evidence Reviewed
Clinical Governance Framework is outlined in the Clinical Governance Plan and supports the OneHealthscope 2025 strategy. The delivery of safe and effective patient centred care is underpinned by eight key pillars outlined in the Clinical Governance Framework which include Leadership and Culture, People and Partnerships, Clinical Data and Outcomes, Managing Risk, Quality Improvement, Evidence Based Practice, Safer Capability Building and Patient Experience. Safety and quality systems are also evident in the Clinical Governance Plan which demonstrate accountability for the improvement of safety and quality services provided to patient, staff and the community.
Rating
Met
Findings
-

Action 1.04
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Evidence Reviewed
Sunnybank Private Hospital has an Acknowledgement of Country - 1.03 February 2022 policy in place with Acknowledgement of Country conducted at the opening of every committee meeting. Artwork by first nations people is on display through the facility. The Sunnybank Private Hospital compendium has commissioned artwork 'Healing Journey' by Aunty Peggy Tidyman along with her autobiography. Sunnybank Private Hospital celebrates National Aborigines and Islanders Day Observance Committee (NAIDOC) week in July with special desserts and tray liners for patient meals, artwork exhibitions and collaborative engagement with local communities. Training in Cultural Diversity and Sensitivity in Health for all staff is available, with the current compliance rate sitting at 91.7%. All Aboriginal and Torres Strait Islander engagement activities are formally documented and monitored by the Quality and Risk Manager.
Rating
Met
Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
Sunnybank Private Hospital uses its Clinical Governance Framework to ensure organisation-wide awareness of safety and quality data. The following elements were verified during the assessment: State Licencing Clinical Indicator Reporting Patient Satisfaction Survey Risk register and Risk Management System Credentialing and scope of practice process for all VMO’s Nurses and VMO’s registration with AHPRA
Rating
Met
Findings
-

Action 1.06
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients
Evidence Reviewed
Clinicians are provided with position descriptions which contain reference to the safety and quality systems in the organisation. Dedicated roles and position descriptions for the following staff were sighted during the assessment: Enrolled Nurse, Registered Nurse, CSSD Instrument Technician, Consumer Consultant, and Director of Nursing. The job descriptions differentiate different levels of responsibility consistent with the role. There is a hierarchy of reporting responsibilities and performance outcome monitoring which ensures the clinical workforce operates within the clinical governance framework. This process was well understood by Management and Staff interviewed during the assessment.
Rating
Met
Findings
-

Action 1.07
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Evidence Reviewed
Policies and procedures are in place to support ongoing review and maintenance of the information available to staff including: Document Control - 1.14 November 2021; Document Retention - Non-Health Information - 1.28 April 2021; Non-Medical Record Forms, Guidelines and SOP Creation and Review - 1.23 October 2021; and Scanning, Quality Checking, Audit and Disposal of Medical Record Forms and Documents - 1.55 September 2023. Reviews are also in response to updated clinical care standards and changes in regulation or the scope of service of the facility. Legislation and regulatory instruments are included in the policy suite. Staff access the policies and procedures via the Intranet "HINT".
Rating
Met

Findings
-

Action 1.08
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems
Evidence Reviewed
The organisation maintains a quality improvement program by identifying areas for improvement, including but not limited to: the incident management and reporting system (RiskMan); internal audit program; patient, staff and VMO feedback; clinical indicator reporting; risk register review; eQuaMS register; and key performance indicator reporting. Consumers and the workforce are involved in the review of safety and quality performance via the committee structure, consumer approved publication process, and national standard portfolios for both consumers and the workforce.
Rating
Met
Findings
-

Action 1.09
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations
Evidence Reviewed
Safety and quality systems and performance reports are provided to the governing body, consumers and the workforce via the committee structure at regular intervals. Meeting minutes are available for staff to access via the L drive. Reports are also communicated throughout the facility on quality and

safety boards for staff, consumers and the community to review. Meeting minutes sighted during the assessment included the Medical Advisory Committee meeting - 01/08/2024, Clinical Governance and Quality Committee meeting 29/07/2024 and the Consumer Partnerships meeting 03/06/2024.

Rating

Met

Findings

-

Action 1.10

The health service organisation:

a. Identifies and documents organisational risks

b. Uses clinical and other data collections to support risk assessments

c. Acts to reduce risks

d. Regularly reviews and acts to improve the effectiveness of the risk management system

e. Reports on risks to the workforce and consumers

f. Plans for, and manages, internal and external emergencies and disasters

Evidence Reviewed

The RiskMan software system is utilised to document and manage the Risk Register with each risk allocated to an "Accountable Executive Member" with a "next review date" documented. The system generates automated reminders to the allocated "Accountable Executive Member ". The register is proactive and is based on clinical risks. Examples of risks include:

Risk ID #11965 Surgical Count - incorrect or incorrectly performed;

Risk ID #11998 Medical Records - inadequate management, storage and disposal;

Risk ID #12009 Patient Identification - failure to identify;

Risk ID #12053 Paediatric Medication - error;

Risk ID #19146 Pandemic (e.g. COVID-19) affecting the community, country or greater population.

Interview with WHS Specialist confirmed that SPH is proactive in planning, managing and reviewing processing around emergency planning including the SPH Disaster and Emergency Plan 2024 and code training.

Meeting minutes sighted during the assessment included the Medical Advisory Committee meeting - 01/08/2024, Clinical Governance and Quality Committee meeting 29/07/2024 and the Consumer Partnerships meeting 03/06/2024.

Rating

Met

Findings
-

Action 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Evidence Reviewed
SPH has a comprehensive incident management and investigation system in place via the RiskMan software system which all workers are trained in and have access to. The system is appropriately designed, resourced, maintained and monitored. The responsibilities for review of the system is clearly identified with incidents sent to the relevant managers and dependent upon the severity managed up through the system for executive review. The Incident Management policy - 2.13 October 2023, was reviewed by the assessment team. Review was undertaken of the RiskMan entries over the last 12 month period which showed the following incidents received and managed: RiskMan ID #326155 Deterioration post operatively; RiskMan ID #115946 Wound infection; RiskMan ID #326075 Perforated bladder; and RiskMan ID #324922 Patient transfer. The SPH CSR - Register for period 1 January 2023- 30 June 2024 was also reviewed with 12 incidents identified and the following five incidents sampled by the assessment team and noted to be reviewed, managed and closed: RiskMan ID #2131918 Open disclosure; RiskMan ID #2121367 Open disclosure; CSR ID #2676 Unexpected death; CSR ID #2872 Fall resulting in serious harm; and CSR ID #2270 Fall resulting in serious harm. All processes undertaken were conducted within the stated policies and procedures of the service and reporting to the MAC was evident through the MAC meeting minutes 01/08/2024.

SPH have implemented a number of programs to support the workforce, carers, patients and families such as the escalation of care process. Assessors observed "Escalation of Care" posters in all patient rooms and clinical waiting areas. Interviews with staff verified that incident management outcomes are provided at staff meetings and used if relevant for the purposes of continuous improvement. Incidents form part of the safety and quality data that is tabled through the committee frameworks.

Rating

Met

Findings

-

Action 1.12

The health service organisation:

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

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

Evidence Reviewed

Sunnybank Private Hospital has an Open Disclosure Policy 2.30 October 2023 and processes that are consistent with the Australian Open Disclosure Framework. Open disclosure processes were verified by the assessment team via review of RiskMan ID #2131918/UR #324914 and RiskMan ID #2121367/UR #079120. There is an opportunity for Healthscope to consider development of a specific open disclosure document to be utilised in the medical record for both transparency of open disclosure processes and ease of documentation requirements for the clinician conducting the open disclosure.

Rating

Met

Findings

-

Action 1.13

The health service organisation:

a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care

b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems

c. Uses this information to improve safety and quality systems

Evidence Reviewed

Sunnybank Private Hospital has a variety of ways to receive feedback from patients, carers and families including, patient experience surveys, QR codes and consumer consultants.

Patient surveys results were sighted by the assessment team for the last two periods: Patient Experience (PEX) 90.4% and Net Promoter Score (NPS) 85.9%, and PEX 90.7% and NPS 86.6%.

Staff were engaged throughout the assessment and reported satisfaction with the workplace, however a recent staff engagement survey completed in 2023 showed results below expected rates and management continually looking at ways to improve staff satisfaction.

Feedback from VMO's is obtained via the Medical Advisory Committee and VMO surveys which are conducted three yearly, last one completed in 2021 with a 66% satisfaction and the next one scheduled for January 2025.

The GM/DON and ADON is accessible as required to both staff and doctors with a positive working relationship observed throughout the assessment.

Rating

Met

Findings

-

Action 1.14

The health service organisation has an organisation-wide complaints management system, and:

a. Encourages and supports patients, carers and families, and the workforce to report complaints

b. Involves the workforce and consumers in the review of complaints

c. Resolves complaints in a timely way

d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken

e. Uses information from the analysis of complaints to inform improvements in safety and quality systems

f. Records the risks identified from the analysis of complaints in the risk management system

g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Evidence Reviewed

Sunnybank Private Hospital has an organisation-wide complaints management system including Complaints Management policy - 1.08 July 2022 to guide and inform staff, as well as the RiskMan software system to report, record, monitor and facilitate the management of the complaint process. The review of several complaints during the assessment demonstrated follow up, action and closure.

Complaints are discussed and reviewed through the committee structure including consumer consultants.

Rating
Met
Findings
-

Action 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher- risk groups into the planning and delivery of care
Evidence Reviewed
Sunnybank Private Hospital has processes in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. Annual diversity reports are conducted with the majority of patients being of English speaking backgrounds.
Rating
Met
Findings
-

Action 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

Evidence Reviewed
Medical Records policies include information on retention and disposal in accordance with state based guidelines and regulation. Medical records were sampled at the point of care and included consent, demographic data, traceability, observation and response charts, discharge summaries, evidence of clinical handover, operative or medical notes as applicable, assessment data and clinical pathways.
Rating
Met
Findings
-

Action 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Evidence Reviewed
Sunnybank Private Hospital has processes outlined in the My Health Record System policy - 2.66 May 2021, to optimise the safety and quality of health care for patients, use national patient and provider identifiers and use standard national terminologies.
Rating
Met
Findings
-

Action 1.18
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Evidence Reviewed
Sunnybank Private Hospital has processes outlined in the My Health Record System policy - 2.66 May 2021, including how to access the systems by the workforce as well as processes to maintain accurate and complete information which is uploaded.
Rating
Met
Findings
-

Action 1.19
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation
Evidence Reviewed
Orientation is provided to all staff though the utilisation of an orientation checklist. Each different staff group having an area specific Orientation Manual including agency staff, student nurses and VMO's. The VMO's are also provided with the Healthscope Limited Hospital By-laws.
Rating
Met
Findings
-

Action 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training

Evidence Reviewed
Initial Assessment: At Sunnybank Private Hospital training is facilitated by the requirements of each staff members role, with a training and competency program in place inclusive of VMO's. Mandatory training includes Basic Life Support (BLS), Manual Handling, Hand Hygiene, Aseptic Technique, Blood Safe (for clinical staff) and Donning and Doffing. Compliance for clinical and non clinical staff excluding the VMO's is currently at 87.5%. The assessment team reviewed the Training Requirements for Credentialed Practitioners - 1.63 May 2024 policy along with the Clinical Governance Gap Analysis for the Training Requirements for Credentialed Practitioners which defines the training requirements inclusive of Hand Hygiene, Basic Life Support or Advanced Life Support (ALS) and Aseptic Technique, however the completion rates for VMO's is in its infancy and therefore this process is not fully implemented. Final Assessment: Sunnybank Private Hospital has implemented several processes to increase VMO mandatory training compliance rates which was evidenced to the assessor at the final assessment. These processes included a weekly email from the DON to the VMO's with results of audits conducted on VMO mandatory training and education, new orientation package for VMO's inclusive of both mandatory training and immunisation requirements as part of the credentialing process as well as an updated onboarding checklist to assist with this process. The VMO register has been updated to include evidence of training and vaccination information. Evidence that discussion of VMO mandatory training at MAC and CRAFT group meeting was verified via meeting minutes 01/08/2024. There has been a significant rise in compliance rates from the initial assessment to the final assessment with current compliance at 76% inclusive of radiologists from Queensland Xray (who need to be credentialed at SPH, but may be infrequent attendees at the facility) and greater than 80% for frequent credentialed VMOs. Sufficient evidence to be downgraded and rated as Met.
Rating
Met
Findings
-

Action 1.21
The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Evidence Reviewed
The eLearning training program included evidence of Cultural Diversity and Sensitivity in Health training for staff with a 91.7% completion rate.
Rating
Met
Findings
-

Action 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Evidence Reviewed
Sunnybank Private Hospital has a staff training and competency program in place that includes annual performance appraisals, this is conducted and monitored via the Nurse Unit Managers of each ward/department. Feedback on training requirements which is identified via this process is incorporated into the annual training needs analysis and action plan.
Rating
Met
Findings
-

Action 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Evidence Reviewed
Sunnybank Private Hospital has in place the Healthscope Limited Hospital By-Laws 2024 policy which outlines credentialing processes. VMO's are assigned scope of practice based on their college training and admitting rights to ensure their scope is clearly defined prior to service provision. Interim rights may be granted depending on scope of practice and risk. Sunnybank Private Hospital conducts an annual Scope of Practice audit via the Measurement Analysis and Reporting System (MARS) to monitor compliance with the credentialing process. There is an opportunity for Sunnybank Private Hospital to strengthen their process around the credentialing of their paediatric anaesthetists, with the formal inclusion of how many paediatric cases they have conducted to maintain their competency and other paediatric experience. The adoption of new technologies is described in the Bylaws and is monitored as a standing agenda item of the MAC.

Rating
Met
Findings
-

Action 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Evidence Reviewed
There is a formal credentialing process for clinicians which is facilitated via the C-Gov system, designed to reflect their scope of practice. AHPRA registration is monitored annually for nursing staff and VMO's. Credentialing of medical officers is described in the Healthscope Limited Hospital By-Laws 2024 policy. The Medical Advisory Committee (MAC) review and approve all new visiting medical officers. Credentialing was completed every five years, however with the newly updated Healthscope Limited Hospital By-Laws 2024 policy implemented on the 3rd of July 2024, credentialing will be completed every three years. Medical Advisory Committee meeting minutes reviewed during assessment 01/08/2024.
Rating
Met
Findings
-

Action 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Evidence Reviewed
Job descriptions contain statements about requirements for incorporating safety and quality principles for staff when fulfilling their role. Discussion with staff during the assessment verified that appropriate supervision is provided to clinicians. Discussion held with management verified that all employed clinicians are provided with position descriptions which outline their role, responsibilities, and accountabilities. Review of position descriptions confirmed the inclusion of safety and quality requirements of staff to their role. Sampling of the following position descriptions: Enrolled Nurse, Registered Nurse, CSSD Instrument Technician, Consumer Consultant and Director of Nursing, verified above processes. Agency staff are provided orientation to their role by senior clinicians.
Rating
Met
Findings
-

Action 1.26
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Evidence Reviewed
Supervision is provided in the facility by appropriately qualified management and staff. The hospital has an after hours Co-ordinator to assist with any issues that may arise out of hours. There is a Resident Medical Officer (RMO) on site at all times in the facility and the VMO's are on call, with verification that contact details are available to staff.
Rating
Met
Findings
-

Action 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice

b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Evidence Reviewed

Sufficient tools and information is available to clinicians at the point of care. Tools include but are not limited to:

Clinical Care Standards; MIMS online; Injectable Drug Handbook online; AMH Australian Medicines Handbook and AMH Children's Dosing Companion.

Rating

Met

Findings

-

Action 1.28

The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes

b. Provide feedback to clinicians on variation in practice and health outcomes

c. Review performance against external measures

d. Support clinicians to take part in clinical review of their practice

e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems

f. Record the risks identified from unwarranted clinical variation in the risk management system

Evidence Reviewed

Clinical indicators are collected and reported via the committee structure and variation in practice is monitored internally. External benchmarking processes include, submitting to the Australian Council on Healthcare Standards (ACHS) clinical data sets. Meeting minutes sighted during the assessment included the Medical Advisory Committee meeting - 01/08/2024 and Clinical Governance and Quality Committee meeting 29/07/2024.

Rating

Met

Findings

-

Action 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Evidence Reviewed
The facility has a preventative maintenance program in place and all biomedical equipment sighted during the assessment contained compliance plates which were noted to be in date. Processes are in place to ensure that infrastructure is fit for purpose. There is also a reactive maintenance process for staff to quickly respond to breakdown of equipment in order to minimise patient risk.
Rating
Met
Findings
-

Action 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Evidence Reviewed
There are documented policies for aggression management. Emergency flip charts were sighted in appropriate locations with staff confirming when they would be used. Verification by the assessment team that there is access to quiet and calm areas if required.
Rating
Met
Findings
-

Action 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Evidence Reviewed
Signage and directions are clear and fit for purpose. It was noted by the assessment team that signage is in both English and Chinese.
Rating
Met
Findings
-

Action 1.32
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
Evidence Reviewed
Discussions with management and staff confirmed that Sunnybank Private Hospital has flexible visiting arrangements in place to meet the needs of patients who stay overnight when it is suitable in meeting the patients needs. Sunnybank implements the Healthscope Visiting Hours - Flexible Arrangements - 2.62 December 2023 policy.
Rating
Met
Findings
-

Action 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Evidence Reviewed
Sunnybank Private Hospital has an Acknowledgement of Country - 1.03 February 2022 policy in place. Artwork by first nations people is on display throughout the facility. The Sunnybank Private Hospital compendium has commissioned artwork 'Healing Journey' by Aunty Peggy Tidyman along with her

autobiography. Sunnybank Private Hospital celebrates National Aborigines and Islanders Day Observance Committee (NAIDOC) week in July with special desserts and tray liners for patient meals, artwork exhibitions and collaborative engagement with local communities. Sunnybank Private Hospital uses the Healthscope Reconciliation Action Plan Jan 2024 - Dec 2025 along with the Sunnybank Private Hospitals Indigenous Engagement Plan 2024-2026, as the framework to guide the facility and to deepen their connection to the First Nations communities within their service provision.

Rating

Met

Findings

-

Action 2.01

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

a. Implementing policies and procedures for partnering with consumers

b. Managing risks associated with partnering with consumers

c. Identifying training requirements for partnering with consumers

Evidence Reviewed

Corporate policies describing the process of Partnering with Consumers include:

Partnering with Consumers policy - 1.05 November 2021

Consumer Approved Publications policy - 2.60 November 2021
Complaints Management policy - 1.08 July 2022.

Volunteers and Consumer Consultants undergo an orientation and training package for the role, which includes a role description, conflict of interest form, confidentiality agreement, consumer consultant foundations training which consists of four part modules and a toolbox resource kit. They complete a Consumer Consultant - Sunnybank Private Hospital profile which includes photo identification and is on display through the hospital.

Confidentiality agreement, conflict of interest form and role descriptions are all signed and this was verified by the assessment team during the review of consumer consultant file for JR.

Rating

Met

Findings

-

Action 2.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers
Evidence Reviewed
The Clinical Governance Framework, outlines the organisation's processes for monitoring partnering with consumers including but not limited to, how improvement strategies are identified and implemented as well as reporting to the highest level of governance via the committee structure. Meeting minutes sighted during the assessment included the Medical Advisory Committee meeting - 01/08/2024, Clinical Governance and Quality Committee meeting 29/07/2024 and the Consumer Partnerships meeting 03/06/2024.
Rating
Met
Findings
-

Action 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers
Evidence Reviewed
Australian Charter of Healthcare Rights (ACHCR) as well as the My healthcare rights for Aboriginal and Torres Strait Islander people are in use and on display throughout the facility. The ACHCR is also available in a number of different languages, including Chinese.
Rating
Met
Findings
-

Action 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Evidence Reviewed
Sunnybank Private Hospital implements the Healthscope documented policy which addresses informed consent - Consent to Medical/Surgical Treatment - 2.17 April 2024 - inclusive of substitute decision maker. The policy also outlines the requirements for doctors own consent forms, which must be reviewed and approved via the MAC. Sunnybank Private Hospital has recently conducted an audit of all consent forms to ensure compliance with legislation and best practice standards. All medical records (n=24) sighted during the review by the assessment team contained a signed consent for the procedure. Monitoring of consent is conducted via the internal audit program.
Rating
Met
Findings
-

Action 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Evidence Reviewed
The Consent to Medical/Surgical Treatment - 2.17 April 2024 addresses the capacity of patients to consent to treatment and to involve a substitute decision maker. Staff have access to interpreter services if required. There is a process in place for checking for Enduring Power of Attorney and Advance Health Care Directives.
Rating
Met
Findings
-

Action 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Evidence Reviewed
Sunnybank Private Hospital has policies and procedures in place to partner with patients to plan, communicate, set goals and make decisions about their care, these include 2024-2025 Sunnybank Private Hospital Consumer Engagement Plan, Healthscope National Consumer Engagement Plan 2024-205, Partnering with Consumers policy - 1.05 November 2021, Complaints Management policy - 1.08 July 2022, Clinical Handover - Departmental and Intra-Unit policy - 8.18 December 2023. This was evidenced in the medical records (n=24) reviewed during the assessment along with the patient episodes of care observed by the assessment team.
Rating
Met
Findings
-

Action 2.07
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care
Evidence Reviewed
Patient centred care is described in the Clinical Governance Framework. Patients are involved in the clinical handover processes. The shared decision making for ongoing care is documented in the patients medical record.
Rating
Met
Findings
-

Action 2.08
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
Evidence Reviewed
The diversity of the population is mainly English speaking and relatively homogenous. The Australian Charter of Healthcare rights (ACHCR) is available in a number of different languages for patients, as well as the My healthcare rights for Aboriginal and Torres Strait Islander people and both are displayed throughout the facility.
Rating
Met
Findings
-

Action 2.09
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
Evidence Reviewed
Consumer Consultants are engaged in the review of patient information and feedback, at a local level as well as participating at the state consumer meeting. Sunnybank Private Hospital implements the Healthscope Consumer Approved Publications (CAP) policy - 2.60 November 2021 and the Consumer Engagement Plan which outline how information is reviewed by consumers, families and their carers.
Rating
Met
Findings
-

Action 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

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

b. Information provided is easy to understand and use

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

d. Information needs for ongoing care are provided on discharge

Evidence Reviewed

Clinical areas were accessed by the assessment team to ensure the organisation supports their staff to communicate with consumers regarding their health care. If necessary, staff will arrange for an interpreter to ensure that communication with a patient is meaningful. Interpreter Service policy - 2.36 June 2022 outlines this process.

Rating

Met

Findings

-

Action 2.11

The health service organisation:

a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Evidence Reviewed

Consumer engagement occurs in two ways. Firstly, via patient centred care at the clinical interface.

The second means is via consumer consultants. Their role is to review the safety and quality data for the facility and provide feedback via the committee structure.

Rating

Met

Findings

-

Action 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Evidence Reviewed
Evidence sighted that the current Consumer Consultants have completed an orientation, have a role description and signed the required documentation including a confidentiality agreement, file for consumer consultant (JR) as well as interview with consumer consultant (JK) verified this process.
Rating
Met
Findings
-

Action 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Evidence Reviewed
Sunnybank Private Hospital uses the Healthscope Reconciliation Action Plan Jan 2024 - Dec 2025 along with the Sunnybank Private Hospitals Indigenous Engagement Plan 2024-2026, as the framework to guide the facility and to deepen their connection to the First Nations communities within their service provision.
Rating
Met
Findings
-

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

Evidence Reviewed
Consumer engagement is a high priority for Sunnybank Private Hospital. The facility has appointed a number of Consumer Consultants to sit on the relevant committees for the different national standards as well as on the Clinical Governance Committee. The Consumer Consultants are also involved in the orientation process of new staff, attend education session to share their experience/stories and are available for staff to offer feedback and consumer views on processes.
Rating
Met
Findings
-

Action 3.01
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d Identifying and managing antimicrobial stewardship risks
Evidence Reviewed
Assessors reviewed infection control and Antimicrobial Stewardship (AMS) procedures and processes which were consistent with the safety and quality systems from the Clinical Governance Standard. These principles underpin the implementation of policies and procedures, risk management and determining training requirements for preventing and controlling healthcare associated infections and antimicrobial stewardship. There is an Infection Control Committee (ICC) with documented Terms of Reference (TOR) in place v3 8/24, the TOR outlines the objectives and KPI's and reporting mechanisms articulated with reporting to the Clinical Governance and Quality Committee. The ICC meeting occurs quarterly. The AMS program is overseen by the AMS Working Group, reporting to the ICC. Staff were able to describe how they operationalise infection control related policies and procedures, how associated risks are managed and describe the training provided regarding antimicrobial stewardship and preventing and controlling healthcare associated infections. SPH has a fulltime Infection Control Co-ordinator with support provided by the National Infection Control Manager. There is a documented position description which outlines the role - Infection Prevention and Control Coordinator 7/22. Infection Prevention and Control Risk Management Plan 2024 was reviewed during the assessment. SPH utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR) to ensure practices are consistent with ACORN and other relevant infection control standards, this includes a two yearly onsite review, with the last review occurring 6/23. The following reports were reviewed

- Sterilising services 88.3 %
- Flexible endoscopes in the Day Procedure Unit 94 %
- Staff health 93.8 %
- Operating Theatre 92 %
- Facility Wide 95.8 %

The facility maintain a Food Business Licence (#A006524777) expiry 01/07/25 with an annual external review undertaken against the food safety program with report dated 05/09/23 sighted.

Risks associated with infections and antimicrobial stewardship are documented within the risk register and reviewed regularly and include the following:

Risk ID #171111 Aseptic Technique - failure to comply

Risk ID #17233 Antimicrobial stewardship - inadequate management of

Risk ID #17112 Hand Hygiene - Inadequate management of

Risk ID #17113 Standard and / or transmission based precautions - failure to implement

Policies are in place and are predominately managed at a Corporate level.

Rating

Met

Findings

-

Action 3.02

The health service organisation:

a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems

b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections

c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections

d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship

e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities

f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship

g. Plans for public health and pandemic risks

Evidence Reviewed
The Infection Control Committee (ICC) has an extensive membership which ensures a multidisciplinary approach is undertaken to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control and AMS systems. There are documented terms of reference sighted - Infection Control Committee (ICC) Terms of Reference V3 August 2024. Training requirements for infection prevention and control and antimicrobial stewardship has been determined and is available to staff via the eLearning platform and monitored via the ELMO Dashboard. The Infection Prevention and Control Co-ordinator receives alerts from Queensland Health which would then be reported through the ICC Meeting. CSSD competencies are completed annually with evidence sighted that staff have access to equipment to implement systems to prevent and control infections. SPH Pandemic Acute Respiratory Infection (ARI) HCF Preparedness Business Continuity Planner 2024 is in place, with risks articulated through the risk register.
Rating
Met
Findings
-

Action 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Evidence Reviewed
SPH has a comprehensive audit schedule which includes infection prevention and control systems and antimicrobial stewardship. Monitoring occurs via the Infection Control Committee and the AMS working group, ensuring that all areas of infection prevention and control and Antimicrobial Stewardship are monitored, improvement measures implemented, evaluated and reported up through to the Clinical Governance & Quality Committee and the Medical Advisory Committee.

Consumers are provided with data via the Clinical Governance & Quality Committee with a Consumer Consultant present. Staff are informed via meetings and displays on noticeboards of all infection control audit results and any actions required.

Meeting Minutes sighted Infection Control Committee 16/07/2024, National Infection Prevention and Control meeting minutes 18/06/2024, Medical Advisory Committee meeting minutes 01/08/2024 and AMS Working Group 20/06/2024.

Rating

Met

Findings

-

Action 3.04

Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Patients and staff interviewed by members of the assessment team were able to describe the actions taken to involve and inform them about infection prevention and control as well as antimicrobial stewardship measures. Information is available to patients, carers and families in a format that is easily understood. Hand hygiene, respiratory hygiene and cough etiquette posters were sighted throughout the facility.

Rating

Met

Findings

-

Action 3.05

The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that:

a. Incorporates national and jurisdictional information in a timely manner

b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation

c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections

d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups

e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation

f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing

g. Monitors responsiveness to risks identified through surveillance

h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Evidence Reviewed

SPH monitors and collects data on healthcare related infections and antimicrobial used as well as broader infection control surveillance data. The collection of clinical indicators is also monitored via The Australian Council on Healthcare Standards (ACHS) clinical Indicator program. The facility contribute to the National Antimicrobial Prescribing Survey (NAPS) annually, 2023 audit results sighted with 72.2 % compliance with guidelines. The program is evaluated and performance is monitored with reports provided to clinicians via the Medical Advisory Committee and also Infection Control Committee. Consumers are provided with data via the Clinical Governance & Quality Committee with a Consumer Consultant present.

Rating

Met

Findings

-

Action 3.06

The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control

of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws

Evidence Reviewed

The review of infection control documents at Sunnybank Private Hospital, specifically transmission based precautions, indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare standard. 15.05 Healthscope Standard and Transmission-Based Precautions 06/23.

Rating

Met

Findings
-

Action 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission- based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Evidence Reviewed
SPH has policies and processes for the management of organisms-specific risks, including prevalence in the community that are consistent with jurisdictional and Public Health advice. Adequate Personal Protective Equipment (PPE) is available for all staff which was verified in the clinical area with Donning and Doffing training provided, with completion rate of 94 % of the surgical ward staff. Fit testing/checking training is undertaken as required with a policy in place to guide and inform both staff and management, 15.09 Fit Testing and Re-Fit Testing of P2/N95 Respirators. Documentation and communication of infectious status is included with all pre-op documentation and communication and is included in discharge summary which is utilised at transfer of care and discharge processes. Staff undertake mandatory training for the appropriate use of standard and transmission-based precautions. Standard and Transmission based precautions are monitored through the audit schedule, dashboard # 271 Transmission Based Precautions 89 % achieved.
Rating
Met
Findings
-

Action 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Evidence Reviewed
Procedures are available for implementing standard and transmission-based precautions. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Environmental management and cleaning practices are consistent with polices. SPH Water Risk Management Plan v2 is in place with Legionella reports sighted - Merieux NutriScience report dated 24/05/2024. Management have implemented a legionella prevention water flushing program with records sighted for July and August 2024.
Rating
Met
Findings
-

Action 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection

Evidence Reviewed
SPH management confirmed that there are processes in place to review data on and respond to infections in the community that may impact patients and the workforce with communication from both Queensland Health and infection control corporate personnel. Communication of a patient's infectious status is included at all transfer of care/handover points and compliance is monitored. Infectious status is documented on the nursing handover report. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry points of clinical areas/patient rooms. Relevant information is provided to patients, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection by the clinical staff and documented in the medical notes.
Rating
Met
Findings
-

Action 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance
Evidence Reviewed
The hand hygiene program is consistent with the current National Hand Hygiene Initiative (NHHI) and jurisdictional requirements. The organisation has access to a number of hand hygiene auditors that have undertaken the NHHI training. Hand hygiene audits sighted by the assessment team included, NHHI Audit Two 2024 with 80 % overall compliance rate achieved and the surgical ward "Bare below the elbow" audit with 100 % compliance. Good hand hygiene practices were observed during the assessment in the clinical areas sampled. Hand hygiene posters were sighted in the clinical area with a "Bare below the elbow Please " also displayed. Evidence was sighted that reports are provided to the workforce, the governing body and consumers via the committee structure. Meeting minutes sighted include Medical Advisory Committee 1/08/2024, Surgical Ward staff meeting minutes 2/07/2024, Standard 3 Preventing and Controlling Infections 16/07/2024 and results displayed in the clinical areas on NSQHSS "How are we doing ?" noticeboards.

Rating
Met
Findings
-

Action 3.11
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique
Evidence Reviewed
Processes for aseptic technique are in place with a corporate policy in place, 8.38 Aseptic Technique 4/22. Staff are appropriately trained, and competency / compliance is monitored which includes the VMO's. Assessors were able to review audit results and identified training compliance. Evidence was sighted that 90 % of staff have completed the ANTT training program. Audits sighted included dashboard #248 Theatre ANTT VMO 90 % compliance achieved and dashboard #318 ANTT 92 % compliance.
Rating
Met
Findings
-

Action 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17
Evidence Reviewed
Training and assessment for the management of invasive devices is available to staff and align with current best practice. Monitoring is conducted through the auditing schedule. Audits sighted Dashboard #260 Invasive Devices 85 % and Dashboard #330 Central Venous Access Catheter Q2 100 %.

Clinical staff monitor invasive devices with records maintained in the medical records.

Rating

Met

Findings

-

Action 3.13

The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 and jurisdictional requirements – to:

a. Respond to environmental risks, including novel infections

b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies

c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections

d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy

e. Use the results of audits to improve environmental cleaning processes and compliance with policy

Evidence Reviewed

Cleaning procedures and schedules are in place with regular auditing and reports made available through the committee structure.

Each cleaner is provided with a cleaning checklist pertaining to their area for the day, a number of these were sampled and found to be complete. Staff interviewed regarding cleaning processes had a good knowledge and understanding of the cleaning requirements. The use of a "Clinell clean sticker" is an effective system to ensure that equipment has been cleaned between patient use. Audits sighted "Environment and Equipment Cleaning Audit" Surgical Ward 2024 with 100 % achieved.

It was verified that the cleaning staff have access to training on cleaning processes for routine and outbreak situations, and novel infections, training is monitored via the ELMO dashboard with current completion rate for cleaning staff is 96.7 %.

The policy 1.29 Procurement 4/24 outlines that all products utilised for cleaning or disinfecting of medical devices are ARTG listed.

Rating

Met

Findings

-

Action 3.14
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Evidence Reviewed
SPH has infection control processes, policies and procedures to respond to infection risks for equipment, devices, products, buildings and linen that is responsive to novel infections risks and pandemic planning. All new products are reviewed and assessed for infection related risk and reported through the Infection Control Committee. Maintenance is both scheduled and responsive to failure. Linen is managed by an external provider with compliance to the AS 4146:2000 standard outlined in the Linen Accreditation Manual 2024. Appropriate handling, transporting and storing of linen was sighted in the clinical areas throughout the assessment. Risks associated with novel infections is addressed through the risk register. Risk ID #19146-Pandemic (e.g. COVID-19) affecting the community, country or greater population.
Rating
Met
Findings
-

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
Initial Assessment: Sunnybank Private Hospital has a Workforce Immunisation policy and program in place which is monitored by the Infection Control Co-ordinator.

15.05 Immunisation for Vaccine Preventable Diseases for Healthcare Workers 07/24.

The program includes annual flu vaccinations which are free for all employees.

Regular reports are provided to the Infection Control Committee Meeting.

Healthcare Infection Control Management Resources (HICMR) report on staff health dated 23/06/2023 with 93.8% compliance achieved.

Confirmed with management that full compliance to the immunisation requirements is obtained prior to commencement of employment.

The service has implemented a risk-based workforce vaccine preventable diseases program. However, the assessors noted that while the VMO vaccinations program has commenced, the process for gathering and recording of VMO vaccinations is not fully implemented.

Final Assessment: Sunnybank Private Hospital has implemented several processes to increase VMO vaccination requirements compliance rates which was evidenced to the assessor at the final assessment. These processes included a weekly email from the DON to the VMO's with results of audits conducted on VMO vaccination requirements, new orientation package for VMO's inclusive of both mandatory training and immunisation requirements as part of the credentialing process as well as an updated onboarding checklist to assist with this process. The VMO register has been updated to include evidence of training and vaccination information. Evidence that discussion of VMO vaccination at MAC and CRAFT group meeting was verified via meeting minutes 01/08/2024. There has been a significant rise in compliance rates from the initial assessment to the final assessment with current compliance for immunisation evidence at 71% inclusive of radiologists from Queensland Xray (who need to be credentialed at SPH, but may be infrequent attendees at the facility) and greater than 80% for frequent credentialed VMOs. Sufficient evidence to be downgraded and rated as Met.

Rating

Met

Findings

-

Action 3.16

The health service organisation has risk-based processes for preventing and managing infections in the workforce that:

a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17

b. Align with state and territory public health requirements for workforce screening and exclusion periods

c. Manage risks to the workforce, patients and consumers, including for novel infections

d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual

e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations

f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection

g. Provide for outbreak monitoring, investigation and management

h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection

Evidence Reviewed
SPH has risk-based processes for preventing and managing infections in the workforce, policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. The program for workforce screening and workplace exclusion is aligned with Queensland Health directions. 2.25 Notifiable Infections Diseases 02/24 SPH Covid 19 Operational Readiness Checklist-v5 07/24 SPH Pandemic Acute Respiratory Infection (ARI) HCF Preparedness Business Continuity Plan 2024 A tiered approach to outbreak and pandemic planning and management is in place. An annual influenza vaccination program is in place. Risks associated with novel infections is addressed through the risk register. Risk ID #19146-Pandemic (e.g. COVID-19) affecting the community, country or greater population. Staff confirmed that management promote non-attendance at work when staff are sick and visitors would be restricted.
Rating
Met
Findings
-

Action 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections
Evidence Reviewed
SPH utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR) to ensure practices are consistent with ACORN, and other relevant infection control standards, which consists of a two yearly onsite review with the last review 22/06/2023. The assessment team reviewed the last report and noted a compliance of 88.3 % for the sterilising services department and 94 % compliance achieved for flexible endoscopes in the Day Procedure Unit with action plans in place to address the recommendations. A gap analysis against the AS 5369 for both the sterilising services department and the flexible endoscopes unit have been conducted.

Traceability processes are in place and are audited through the auditing system.

Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections are outlined in the sterilising services policies and procedures provided by HICMR.

Rating

Met

Findings

-

Action 3.18

The health service organisation has an antimicrobial stewardship program that:

a. Includes an antimicrobial stewardship policy

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

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

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

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

Evidence Reviewed

The facility has established an antimicrobial stewardship program that is guided by an evidenced based policy which includes both a corporate policy and a local site policy, 18.53 Antimicrobial Prescribing and Management 05/24 and SPH 1.10 Antimicrobial Stewardship 08/24. Both policies sighted are consistent with the antimicrobial stewardship clinical care standard. A gap analysis to the antimicrobial stewardship clinical care standard was also sighted by the assessment team.

Displayed in all clinical areas is the Antimicrobial Stewardship poster with a QR code providing access to prescribing guidelines to assist prescribers.

Discussion with the Pharmacist confirmed that the prescribing process is in accordance with the Therapeutic guidelines, list of restricted antimicrobials and approved processes with specialist or senior clinician review. The facility has access to an Infectious Disease Physician who attends both the ICC and the Antimicrobial Stewardship working groups.

Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use.

Evidence was sighted that results of antimicrobial use and appropriateness audits are utilised to promote continuous quality improvement via both the minutes of the ICC and the Antimicrobial Stewardship working group.

Rating

Met

Findings
-

Action 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Evidence Reviewed
Documentation showed that the antimicrobial stewardship program is audited to review the antimicrobial prescribing and use, including surveillance data on antimicrobial resistance. The program is evaluated and performance is monitored. The facility submits data to the National Antimicrobial Prescribing Survey (NAPS) and are considering the submission of data to National Antimicrobial Utilisation Surveillance Program (NAUSP). Surveillance data on antimicrobial resistance and use is communicated to the VMO's via the Medical Advisory Committee to support appropriate prescribing with the pharmacist now reviewing stop dates for all antimicrobials. Evaluating the performance of the antimicrobial stewardship program, identifying areas for improvement, taking action to improve the appropriateness of antimicrobial prescribing and use occurs through the Antimicrobial Stewardship working group with minutes sighted for 20/06/2024. The Antimicrobial Stewardship working group reports to ICC, Medication Committee, Clinical Governance and Medical Advisory Committee as set out in the SPH Committee Structure 2024. The Infectious Disease Physician is a member of the Medical Advisory Committee and provides guidance on all matters relation to antimicrobial prescribing. Medical Advisory Meeting minutes sighted 01/08/2024. National Antimicrobial Prescribing Survey (NAPS) 2023 results sighted with 72.2 % compliance with guidelines. Dashboard #255 Antimicrobial Audit Quarter 3 2024 83 %. Antibiogram report sighted 01/2023 -31/12/23.

Rating
Met
Findings
-

Action 4.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Evidence Reviewed
Sunnybank Private Hospital has a hospital-wide system for safety when supplying, storing, prescribing and administering medication. A system for the reporting of medication incidents is in place and the hospital continues to strive to operate in a culture that encourages staff to report any medication incident or near miss which are recorded in RiskMan. Risks associated with medication management are documented within the risk register. There is a suite of corporate medication policies. There is only one local policy for medications and it is to do with the Management of Medication and Treatment Errors SPH1.04. Sunnybank Private Hospital has identified training requirements for medication management which are undertaken through the online Elmo e-learning system. RiskMan was reviewed from 1/8/2023 - 27/8/2024 with 90 incidents and near miss reports noted. Training registers were reviewed on site. It was noted ICU staff demonstrated 100% compliance to Intravenous (IV) Medication Administration and Vasoactive Medication Management. The medical ward staff demonstrated in the sample reviewed 44/48 staff had completed their Medication Administration competency assessment.
Rating
Met
Findings
-

Action 4.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the effectiveness and performance of medication management

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

c. Reporting on outcomes for medication management

Evidence Reviewed

Nurse Unit Managers (NUMs) undertake rounding exercises daily. They are designed to assess and improve the effectiveness of the medication management system. The rounding audit includes a review of the Medication Chart completion, medication storage, disposal, high risk medications and medication resource availability.

The Corporate Medication Safety Group last met on 13/8/2023. The local Sunnybank Private Hospital Medication Management Meeting was held on 18/7/2024. Items discussed included a safety share, patient reflection noting missed medications during their stay, patient feedback (patient waited 20 mins for pain relief) and medication incidents were reviewed (Q2 0.15% against benchmark of 0.3%). Data is analysed into ward frequency, trends over the past three months, location of the event, and the outcome. Hospital Acquired Complications (HAC) are discussed, clinical indicators and shared learning regarding incidents were discussed. Amended or new policies and the medication safety committee meeting minutes from 30/5/2023 were discussed. Audit results, accreditation recommendations, high risk medication risks and controls were reviewed. Education, training, pharmacy activities, patient information, TGA Reports and PBS changes were reviewed at the meeting.

The internal audit program has a role in monitoring and improving the effectiveness and performance of medication management system. MARS audit tools are utilised and the reporting processes are noted above. Audit #276 National Standard Medication Chart Mini Audit was attended 26/7/2024. ICU sampled 14 patients, Medical/Rehabilitation ward sampled 46, Surgical ward sampled 22. The audit included high risk medications and injectables and was completed on the 26/07/2024. Results were discussed at the Clinical Standards committee, Quality committee, Medical Advisory committee, craft groups, Staff meetings.

Incidents are monitored and trended. There were 90 medication incidents in the 12 month period ending 27/8/2024. This was less than the previous year.

Actions plans are formulated in response to system inputs. An example of a Quality Action Plan (QAP) #14533 in response to lower audit results for the documentation of medication in the controlled drug books. The QAP was closed 12/6/2024 following an increase in compliance.

Rating

Met

Findings

-

Action 4.03

Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed
HPS Pharmacy Services are contracted to Sunnybank Private hospital. A medication reconciliation process was observed during the assessment. A Medication Management Plan Review by HPS Pharmacy staff for patient UR #328485 was very interactive, shared decision making was evidence. The patient was also offered information on the range of medications he was prescribed. Medication Reconciliation is outlined in the Obtaining the Best Possible Medication History policy 18.85.
Rating
Met
Findings
-

Action 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Evidence Reviewed
The facility Bylaws outline the scope of practice for prescribing, dispensing and administering medicines for clinicians. Corporate policies supporting the indicator include but are not limited to: - Antimicrobial prescribing and management 18.53 - Management of cannabis medicines 18.07 - Ordering Medication – Verbal 18.50 - Administration of Medication by Enrolled Nurse 18.02 - Medication Orders and Administration 18.01 - Registered Nurse/Registered Midwife – Initiated Medications 18.52
Rating
Met
Findings
-

Action 4.05
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
Evidence Reviewed
The HPS Pharmacy Manager was interviewed on site and confirmed her teams involvement in provided medication reviews as noted in the Medication Management Plan policy 18.75.
Rating
Met
Findings
-

Action 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Evidence Reviewed
In the files reviewed on site (n=24), there was universal evidence of staff seeking and confirming the medication history of their patients on admission as per the Medical History HMR 4.5, which was present in the files reviewed. UR #225358 contained a current Medication Management Plan. The document contains the purpose of the medication, any changes during the admission and specific instructions.
Rating
Met
Findings
-

Action 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Evidence Reviewed
Staff ask and confirm the medication history of patients on admission against the History Form HMR 4.5. There is an area on the Alert form and the Medication Chart to document adverse reactions. Rounding audits are completed by the NUMS in each ward to test staff compliance with documentation and shift to shift handover of adverse drug reactions. Two episodes of administration of S8 medications were observed during the assessment. UR #326373 and #314337, two staff attended the bedside and confirmed the presence and type of allergies with the patient and reconciled the verbal information against the medication chart.
Rating
Met
Findings
-

Action 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Evidence Reviewed
There is an area on the Alert form and the Medication Chart to document adverse reactions. Any adverse reactions would and are entered into the RiskMan software. Each day, nurses update the Alert form to ensure any new or emerging situations or events are captured and subsequently communicated.
Rating
Met
Findings
-

Action 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Evidence Reviewed
There is a policy, 18.76 Reporting to TGA of Adverse Drug Reactions. The HPS Pharmacy Manager confirmed the process.

Rating
Met
Findings
-

Action 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Evidence Reviewed
There are both policy and templates for medication reviews. The Medication Safety Governance policy 18.89 includes advice on the safety of the medication system throughout the Healthscope network of care. Criteria for medication reviews results in almost all Medical Rehabilitation patients having a pharmacist medication review. The process appeared to be well managed and monitored in the facility.
Rating
Met
Findings
-

Action 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Evidence Reviewed
In addition to the Medical staff providing information on the medication they provide to patients, the HPS pharmacy staff are also involved. A series of brochures are provided to the patients by HPS pharmacies these include but are not limited to antibiotics, paediatric discharge medication, analgesics or pain relievers, anticoagulants and eye medications.
Rating
Met

Findings
-

Action 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes
Evidence Reviewed
HPS pharmacy software generates a list of current medications and the reasons for taking them along with any changes. In three files reviewed of patients who were transferred out of the facility the printed list of medication was included in the patients chart. On discharge a current medication's list and the reason for any changes to their existing medications are included. Policies to assist staff include Discharge Medication 18.49.
Rating
Met
Findings
-

Action 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Evidence Reviewed
Medication prescribing decision support tools are readily available for clinicians including copies of The Australian Injectable Drugs Handbook and access to eMIMS, Therapeutic Guidelines and NPS Medicine Wise available on all computer desktops. All these are known to and accessible to the staff.
Rating
Met
Findings
-

Action 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
Evidence Reviewed
Sunnybank Private Hospital complies with all jurisdictional and legislative requirements for the safe and secure storage of medication as per the Storage and Administration of Controlled Drugs policy 18.56 and the Storage of Temperature-sensitive Medications policy 18.86. Ward refrigerators are monitored with readings recorded on CH 1.04 Drug Fridge & Room Thermostat Monitoring form (August 2024 for Day Oncology was sampled and found to be appropriately completed). Medsafe fridges are used and appropriately maintained with data loggers in place and back to base alarm systems for alerting staff. Disposal of Medications policy 18.78 is available. In the ward areas there are clinical waste bins for disposal. The HPS Pharmacy keeps an expired drug log.
Rating
Met
Findings
-

Action 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
Evidence Reviewed
High Risk Medication Management is outlined in the Storage and Administration of High-risk Drug policy 18.56. There are appropriate registers located in all clinical areas that utilise S4 and S8 medications. Keys are kept by the senior registered nurses. Discards are documented. A sample from the medical ward dated 20/8/2024 for patient UR #323876 was noted for discarding 50mcg Fentanyl. Controlled Drug Audits are documented weekly in the registers. APINCH posters and Tall Man lettering are used to designated high risk medications at the point of use. The Medication Committee reviewed high risk medication risks and the appropriateness of current controls on the 18/07/2024.

Rating
Met
Findings
-

Action 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Evidence Reviewed
Sunnybank Private Hospital and Healthscope as a whole support the attainment of this indicator through appropriate safety strategies when delivering comprehensive Care. Systems and processes are based on best practice guidelines and industry standards. The system supports clinicians to deliver comprehensive care. A range of mandatory training is required for staff regarding comprehensive care with the compliance rate for all training attendance monitored by management. Elmo software is used. There is a spreadsheet that is separated by clinical area. This document lists both mandatory and discretionary training. Staff training was sighted across the wards and departments, this is monitored by the Nurse Unit Managers. The Risk Register lists Failure to recognise a history of cognitive impairment or develop during an admission as Risk #20042. This risk is required to be reviewed 3-6 monthly. Risks are managed through the risk register and updated at least annually. Monitoring of incidents, adverse events, and patient feedback is managed through RiskMan software. The local SPH specific policy suite for comprehensive care includes: SPH1.01 Admission Eligibility, SPH1.02 Admission Exclusion Criteria, SPH1.06 ICU Admission Guidelines, SPH1.11 Management of Acute Stroke and SPH1.16Advance Care Directives. Healthscope Corporate policies include, but are not limited to - 8.94 Delirium and Cognitive Impairment Prevention and Management - 8.97 Dysphasia management - 8.27 Diet and Nutrition - Adult inpatients - 8.05 Pressure Injury, Prevention and Management of - 8.07 Triage - 8.06 Venous Thromboembolism

- 8.98b Voluntary Assisted Dying
- 8.04 Falls, Prevention and Management - Patient

Rating

Met

Findings

-

Action 5.02

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

a. Monitoring the delivery of comprehensive care

b. Implementing strategies to improve the outcomes from comprehensive care and associated processes

c. Reporting on delivery of comprehensive care

Evidence Reviewed

Monitoring of the delivery of comprehensive care occurs via the internal audit schedule. Minimising Harm Audit was completed 02/05/2024 and the Comprehensive Care Audit was completed 02/05/2024. Both audits demonstrated acceptable results in the Medical/Rehabilitation ward. In the intensive care ward, two quality action plans were initiated with the aim of increasing compliance with seeking goals of care from patients. The first, #15487 focussed on evaluating the progress in achieving the goal and consistent documentation of the process. The second, #15488 on ensuring the 4AT assessment tool was appropriately utilised.

Reporting of the process of these actions is linked to the quality activity program, which is the responsibility of the Quality Manager, and by association, the National Quality and Risk Manager.

Rating

Met

Findings

-

Action 5.03

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Staff were observed to actively involve patients in their own care and have a focus on inclusion and shared decision making. The staff ensure the patient comprehends the information provided. The patients interviewed on site stated they were happy with the information provided and they understood it. At the ward level, the patients were seen to be engaged in the clinical handover process. Staff included them in the process and consistently sought and confirmed goals of care during handover. Handover was witnessed for two allocations of staff on the medical/rehabilitation ward, UR #284587, #15251, #328273 and 325216.

Rating

Met

Findings

-

Action 5.04

The health service organisation has systems for comprehensive care that:

a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment

b. Provide care to patients in the setting that best meets their clinical needs

c. Ensure timely referral of patients with specialist healthcare needs to relevant services

d. Identify, at all times, the clinician with overall accountability for a patient's care

Evidence Reviewed

The facility has identified a system for the delivery of effective care that utilises a Comprehensive Risk Screening Tool, HMR6.13G. The tool includes assessment for cognitive impairment, medication management risk, malnutrition risk screening, full screening, venous thromboembolism, mental health, behavioural issues, skin, integrity, and pressure injury. If a patient screens positive, this initiates the corresponding care plan. A new HMR6.13G is mandated should a patients condition change. The identified care needs are delivered in accordance with the HMR6.13H, Comprehensive Care Plan. Nurses sign to acknowledge the completion of the task in collaboration with the patient.

Rating

Met

Findings

-

Action 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Evidence Reviewed
To facilitate appropriate planning, the Discharge Planning RN attends a multidisciplinary team meeting. Attendees include occupational therapists, physiotherapist, social worker, dieticians, medication clinicians and nurses. The aim of the meetings are to link patients with supports prior to leaving hospital. Examples were discussed including transfers to other facilities. These may be St Vincent's at Kangaroo Point or Metro South Community Palliative Care team. Nursing home placements and ACAT assessments are facilitated. Liaison with occupational therapists to ensure there is access to equipment for complex care needs. Medication discussions are included by the pharmacists. 10.09 Case Conference and 10.01 Discharge Planning policies noted for Rehabilitation patients
Rating
Met
Findings
-

Action 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Evidence Reviewed
Nurses sign the HMR6.13H, Comprehensive Care Plan to acknowledge the completion of their tasks in collaboration with the patient.
Rating
Met
Findings
-

Action 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the ‘Minimising patient harm' criterion
Evidence Reviewed
The use of the Comprehensive Risk Screening Tool, HMR6.13G ensures comprehensive screening processes are implemented. This risk screening tools is utilised on admission and throughout the patient journey enabling the effective management of risk, prevention of deterioration and the development of an individualised appropriate care plan, provision of ongoing care, referral to appropriate disciplines and services through to discharge.
Rating
Met
Findings
-

Action 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Evidence Reviewed
Sunnybank Private Hospital has processes in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information system.
Rating
Met
Findings
-

Action 5.09
Patients are supported to document clear advance care plans

Evidence Reviewed
Advance Care Plans can be completed on site. There is a form available on the intranet along with contacts for chaplaincy and a Justice of the Peace. If a patient has an existing Advanced Care Directive (ACD), staff request a copy for the medical record which is documented on the Alert Sheet MR00. Staff describe asking for a copy and filing it in the patients medical record. The NUM notes compliance with documentation is an ongoing project for the Rehabilitation/Medical ward.
Rating
Met
Findings
-

Action 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Evidence Reviewed
Screening patients is commenced via the Medical History HMR4.5. The document includes questions on the patient's history, examples include but are not limited to recent falls, medication and other allergies, mental health, MRSA, Covid, other infections, social situation, diet, the presence of an advanced care directive, transfusion history, aggression needs, skin issues and diet.
Rating
Met
Findings
-

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process

Evidence Reviewed
The facility uses a Comprehensive Risk Screening Tool, HMR6.13G. The tool includes assessment for cognitive impairment, medication management risk, malnutrition risk screening, full screening, venous thromboembolism, mental health, behavioural issues, skin, integrity, and pressure injury. If a patient screens positive, this initiates the corresponding care plan. A new HMR6.13G is mandated should a patients condition change. The identified care needs are delivered in accordance with the HMR6.13H, Comprehensive Care Plan. Nurses sign to acknowledge the completion of the task in collaboration with the patient.
Rating
Met
Findings
-

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Reviews of the medical records conducted on site verified the documentation of relevant alerts. The Alert form is MR1. The files reviewed included UR #328269, #328260, #327867, #327026, #327867, #225358, #213144, #314337, #328441, #327267, #328482, #272319, #328438, #327774, #328107, #328299 and #328485.
Rating
Met
Findings
-

Action 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care

e. Includes a plan for referral to follow-up services, if appropriate and available

f. Is consistent with best practice and evidence

Evidence Reviewed

Evidence was sighted in the patient medical records and via observed episodes of care to verify the staff undertake shared decision making in the development and documentation of a comprehensive and individualised plan. Risks are identified utilising the HMR4.5 with further assessment completed on the HMR5.13G. Outcomes of risks are documented on the Patient Alert Form MR1 which forms part of the clinical handover process.

Discharge planning goals are discussed during the admission process with identification of the patients support person completed/confirmed at this point.

Goals of care are sought at the commencement of each staff members shift, they are documented in both the medical record and the care board in the patients room. The care board is visible to the patient. The nature of the admissions to the hospital included referrals for follow up. These referrals are identified in a multidisciplinary team environment led by the treating clinician in conjunction with the discharge planning team.

Clinical Care Standards have been identified and direct the care in the hospital according to industry best practice.

Rating

Met

Findings

-

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. Use the comprehensive care plan to deliver care

b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care

c. Review and update the comprehensive care plan if it is not effective

d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Evidence Reviewed

Evidence was provided on site, largely in the medical records that the team work in partnership with all stakeholders to deliver good care for the patient. Monitoring of the effectiveness is via the internal audit schedule. The NUMs undertake rounding exercises to ensure staff are acting on the patients condition in accordance with the care plan. During clinical handover, the staff review their progress towards meeting the patients goal of care for that day. Sometimes, the goals are overarching treatment bases and sometimes they are small comforts that make the patient more comfortable. Reassessment of the care plan is interactive and constant. It occurs in response the patients clinical and emotional condition at the time. Documentation occurs in the medical record.

Rating
Met
Findings
-

Action 5.15
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
End of life (EOL) care is not common at Sunnybank Private Hospital. Patients are generally not admitted to enter the EOL pathway. Patients who deteriorate and do not have lifesaving measures identified can be retained and nursed accordingly. Healthscope HINT intranet includes the Last Days of Life Toolkit - Management Planning and Care After Death - Adult Patients, which has been adapted with permission from the Clinical Excellence Commission's 2017 work on end of life. Resources include: - Healthscope Last Days of Life Care and Management policy 8.96. - HMR3.21 Care After Death in Hospital - HMR 6.44 Initiating Last Days of Life Management Plan - Adult - Understanding your Grief CEC Document.
Rating
Met
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
Advice is sought from the Metro South Palliative Care Team if required. The Physicians do not admit for palliation.

Rating
Met
Findings
-

Action 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Evidence Reviewed
Advance Care Plans are sought from patients and documented on the Alert Sheet MR001. Staff describe asking for a copy and filing it in the patients medical record. The NUM notes compliance with documentation is an ongoing project for the Rehabilitation/Medical Ward.
Rating
Met
Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Evidence Reviewed
There is a SPH Intranet page that holds resources for the staff who are providing end-of-life care and support to patients and their families.
Rating
Met
Findings
-

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Evidence Reviewed
Initial Assessment: There is a new process in development to assist the facility to review the quality of end-of-life care against the patients planned goals. The hospital Social Worker plans to engage with relatives of the deceased to assess the death by using five simple questions. This process is a quality improvement, planned to augment the existing process whereby the after hours hospital co-coordinators liaise with the family post death to assess if the plans of their loved one were met. The plan was documented in eQuaMS with an identification number of #13086 dated 7/3/2024. Final Assessment: The assessor was able to verify at the final assessment that planned processes at the initial assessment had been implemented for routinely reviewing the safety and quality of end-of-life care that is provided to their patients against the patients/families planned goals of care. The hospital social worker has now been engaged to provide the posthumous calls after a 4-6 week period. Evidence of auditing and reporting of these results was reviewed by the assessor via meeting minutes from the NS5 Comprehensive Care meeting 18/10/2024 and the Internal Medicine/Rehabilitation/Oncology CRAFT Group meeting 18/10/2024. Further evidence that processes have been implemented to meet the requirements of this action includes a draft "death and dying" education module to support staff providing end-of-life care, audit and feedback results will be discussed at the national Consumer Partnership meeting scheduled for December 2024 along with standing agenda item at the MAC, the Mortality and Morbidity committee and the Clinical Governance and Quality committee. The assessor also reviewed the Mortality Spreadsheet inclusive of EOL Care Survey, to aid in the monitoring that this process.
Rating
Met
Findings
-

Action 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
Medical record reviews confirm the processes clinical staff undertake to make shared decisions regarding end of life with the patient and their family. Deceased patient charts UR #013150 31/7/2024 and #669308 were reviewed with documentation of collaboration with family. The evidence consisted of comfort measures, desires to stop treatment and remove therapeutic devices. Notations regarding the support of grieving family members was also recorded in the medical record.

Rating
Met
Findings
-

Action 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Evidence Reviewed
Sunnybank Private Hospital has a system for screening, assessment and provision of a care plan for patients with or at risk of pressure injury as noted in the 8.05 Prevention and Management of Pressure Injury policy. There is provision for a skin assessment to be performed on admission and reviewed on discharge. Pressure injury incidents are reported in RiskMan and reviewed and monitored via the Healthscope committee structure. There is a Comprehensive Care Committee with meeting held.
Rating
Met
Findings
-

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

Findings
-

Action 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries
Evidence Reviewed
Staff have appropriate equipment available to them to aid in managing risks to skin integrity. Equipment, products and devices, including positioning gel pads and other positioning accessories, are available to prevent and manage pressure injuries, the assessor witnessed these products in use. Mepilex was verified for a patient in the Medical/Rehabilitation Ward. This was communicated and the dressing sighted during clinical handover for patient UR #325216.
Rating
Met
Findings
-

Action 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Evidence Reviewed
All patients are assessed on admission against a standardised screening tool. Incidents are reported into RiskMan and data related to falls is analysed and reported through the Falls Committee. There were notice boards in the hospital designed to educate patients on how to prevent falls. The facility has multiple strategies to minimise falls, these include but are not limited to sensor mats, call bell within reach, room locations varied depending on acuity and patient education. Fall Management is in line with best-practice guidelines. Alert forms are held in the patient medical record at the point of care in order to keep the falls risk status front of mind.

When a fall occurs, an episode sticker is placed in the patient file. RiskMan reports are trended and analysed throughout the hospital committee structure. This was verified in a view of meeting minutes.

Documentation reviewed supported the appropriate management.

Falls risks in paediatrics are identified and managed appropriately.

Rating

Met

Findings

-

Action 5.25

The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls

Evidence Reviewed

All patients are assessed on admission against a standardised screening tool. Those patients that are identified as a falls risk are managed as per 8.04 Patient Falls, Prevention and Management. All falls are reported into RiskMan and data related to falls is analysed and reported through the Quality, Clinical Review, Medical Advisory and Executive Committee meetings.

Rating

Met

Findings

-

Action 5.26

Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies

Evidence Reviewed

Information is available to patients, their carers / families about falls prevention and risk management strategies. The information is in the form of falls brochures and posters throughout the facility. Rehabilitation patients visiting the gym are educated and supported to minimise their falls.

Rating
Met
Findings
-

Action 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Evidence Reviewed
Sunnybank Private Hospital has a system for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice. Ward staff were seen to ensure meals were placed in reach of clients. Comprehensive care plans identify patients who require assistance with meals or special diets including allergies.
Rating
Met
Findings
-

Action 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Evidence Reviewed
Patients’ nutritional and hydration requirements, preferences, allergies and special dietary needs are identified and assessed on admission. Screening for weight, health and nutritional status identifies patients at risk. Dietician referrals are sought. The facility has a monthly menu plan. There are a range of dietary supplements available in the wards.

Described processes were verified where relevant in the files sampled.
Rating
Met
Findings
-

Action 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Evidence Reviewed
Sunnybank Private Hospital has systems in place to care for patients who have cognitive impairment, at risk of developing delirium or are experiencing cognitive impairment. Validated tools and resources are used to ensure early recognition, prevention, treatment and management is undertaken. Monitoring of the patient is in accordance with ACSQHC and Healthscope Requirements. The prevailing policy is 8.94 Delirium and Cognitive Impairment Prevention and Management. The Opioid Stewardship Standard has been adopted in order to minimise risks to patients. The HPS pharmacists conduct medication reviews and instigate Medication Management Plans. The Comprehensive Care Audit tool monitors compliance with processes monthly. There is a risk screening process in place, via Healthscope HMR6.13G Comprehensive Risk Screening tool. There is a QAP, #15317 to ensure compliance with the Clinical Care Standard for use of antipsychotics and other psychoactive medicines . The action is ongoing and represents acknowledgement of Sunnybank Private Hospitals integration of best proactive patient management.
Rating
Met
Findings
-

Action 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Evidence Reviewed
The 4AT screening tool is used for all patients over 65 years of age, and 45 years if the patient is of Aboriginal and Torres Strait Islander heritage. Families and carers are engaged in the process where possible. An interview with one of the rehabilitation physicians described the multidisciplinary approach to caring for the high percentage of admissions with some form of cognitive impairment in line with the clinical care standard.
Rating
Met
Findings
-

Action 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Evidence Reviewed
Sunnybank Private Hospital has systems in place to support collaboration with patients, carers and families to identify when a patient is at risk of self-harm or suicide, as per 2.35 Self-harm and Suicide (Threatened, attempted or completed) in a Non-mental Health Facility. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation. Staff describe if a patient was identified at risk of self-harm or suicide, this would be escalated and transferred to a facility with appropriate mental health services. Admission screening would assist in appropriate referral prior to admission. RiskMan incident reporting and management system is used for reporting. Staff education regarding management and escalation of patients requiring mental health support is conducted. De-escalation strategies by senior staff are described. The After-hours managers are experienced registered nurses.

Rating
Met
Findings
-

Action 5.32
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Evidence Reviewed
Healthscope ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thought. The patient is safely transported (using emergency services if required) to an appropriate mental health facility.
Rating
Met
Findings
-

Action 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Evidence Reviewed
There is a documented policy in place to inform and guide staff to identify and mitigate situations that may precipitate aggression. - SPH 6.15 Occupational Violence and Aggression Management – Principles and Prevention Workplace Emergency Procedure Flip charts are positioned at telephone points in the day surgery which provides a quick reference on what to do in the event of all types of emergencies such as personal threat.
Rating
Met

Findings
-

Action 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
Evidence Reviewed
Processes are in place for the identification and management of potential aggressive or violent behaviour. Staff were able to describe processes that work with patients to minimise aggression and potential violence. All incidents involving aggression are reported through the incident management system RiskMan for further review and management. Emergency Procedures Flip Charts and alarms are in place for emergency responses and noted quiet spaces within the facility to assist with de-escalation processes.
Rating
Met
Findings
-

Action 5.35
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body
Evidence Reviewed
Sunnybank Private Hospital has processes to guide the use of restraint in accordance with legislative requirements. Advice is included in 8.95 Restrictive Practices – Patient Restraint Non-mental health Facilities. All reporting is via RiskMan and is communicated to the governing body. There were zero reports of restraint in RiskMan year to date.

Rating
Met
Findings
-

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

Action 6.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Evidence Reviewed
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. 2.15 Correct Patient, Correct Procedure, Correct Site 07/22 8.08 Clinical Handover - Departmental and Intra Unit 12/23

2.08 Patient Identification Bands 03/24

Risks are managed through the risk register with regular reviews conducted to ensure appropriateness.

Risk #16744 Clinical Handover- Failure

Risk #12009 Patient Identification - failure to identify

Risk #12072 Wrong patient / wrong procedure / wrong site surgery/Anaesthesia is performed

Risk #12073 Wrong patient has surgery/procedure

Training is completed via an eLearning platform and monitored via ELMO Dashboard. Evidence was sighted that ongoing education is provided to staff with current eLearning for Clinical Handover is 84.15 %.

Rating

Met

Findings

-

Action 6.02

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

a. Monitoring the effectiveness of clinical communication and associated processes

b. Implementing strategies to improve clinical communication and associated processes

c. Reporting on the effectiveness and outcomes of clinical communication processes

Evidence Reviewed

Monitoring the effectiveness of clinical communication and associated processes occurs through RiskMan and identified via patient feedback, audits and the incident reporting process.

Implementing strategies to improve clinical communication and associated processes was evidenced through the quality action plans #15261 Theatre to Recovery /ICU handover checklist and #15140 Theatre time out- Day surgery and Main Theatre.

Reporting on the effectiveness and outcomes of clinical communication processes occurs via the Standard 6 Communicating for Safety Meeting with minutes sighted for 2/07/2024.

Rating

Met

Findings

-

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

Action 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Evidence Reviewed
Sunnybank Private Hospital has clinical communications processes to support effective communication for when identification and procedure matching should occur which is outlined in the policies, 2.15 Correct Patient, Correct Procedure, Correct Site 07/22, 8.08 Clinical Handover - Departmental and Intra Unit 12/23 and 2.08 Patient Identification Bands policy 03/24. The policy Clinical Handover - Departmental and Intra Unit 12/23 articulates the ISBAR framework which has been implemented as a standardised approach to communication, this was verified during varied clinical handover episodes of care between multidisciplinary teams witnessed during the assessment (UR #148503, #12755, # 36473, #25762, #187945, #316068, #328394 and # 328385).

Critical information about a patient's care, including information on risks, emerges or changes are documented within the patients medical records and were noted to updated as required.

Rating

Met

Findings

-

Action 6.05

The health service organisation:

a. Defines approved identifiers for patients according to best-practice guidelines

b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated

Evidence Reviewed

Sunnybank Private Hospital has policies that define the use of approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used.

Assessors verified this when observing admission, clinical handover, time out process and administration of medication.

Rating

Met

Findings

-

Action 6.06

The health service organisation specifies the:

a. Processes to correctly match patients to their care

b. Information that should be documented about the process of correctly matching patients to their intended care

Evidence Reviewed
Processes are in place for surgical / procedural time-out, this is documented on the Surgical Safety and Fire Checklist. Regular audits are conducted to ensure compliance. There is a policy in place to guide and inform staff, 2.15 Correct Patient, Correct Procedure, Correct Site 07/22. Surgical / procedural time-out was witnessed during the assessment with documentation undertaken in the medical records UR #109781 and #328397. Time out posters are displayed in all operating theatre to inform, remind and guide staff on this important process. Auditing of this process is undertaken with audit sighted- Dashboard #292 Theatre Time Out Audit SPH 08/2024 98 %.
Rating
Met
Findings
-

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

Action 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Evidence Reviewed
The assessors witnessed clinical handover that was structured and effectively engaged with patients, their carers and families in defining goals of care and decision making during the admission and discharge processes. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making.
Rating
Met
Findings
-

Action 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Evidence Reviewed
Sunnybank Private Hospital has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Clinical handover involves patients, their carers and families as required. Clinical handover is audited, and incidents / feedback related to communication issues are addressed through the committee framework.
Rating
Met

Findings
-

Action 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Evidence Reviewed
Documentation and patients witnessed episodes of care verified that there are communication processes in place for patients, carers and families to directly communicate critical information and risks about care. This process commences at the admission process and right through to the discharge process. Processes are in place for patients, carers or families to directly escalate care with posters displayed throughout the hospital.
Rating
Met
Findings
-

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

Findings
-

Action 7.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Evidence Reviewed
Healthscope Ltd have implemented a number of Corporate Policies for blood management. 8.64 Blood Transfusion - Management of Patient , Blood and Blood Products 09/2023 8.62 Blood Transfusion - Massive 11/2021 8.63 Blood Transfusions (Emergency) of unmatched Red Cells 06/24 8.64 a Blood Fridge Management and unused blood products 11/20 8.87 Jehovah's Witnesses and other Patients Refusing Blood Transfusions Therapy 06/24 Local site policies and work processes sighted SPH 1.12 Blood Administration 06/24 SPH Work Process 1.25 Blood Fridge Checks SPH Work Process 1.13 Weekly Blood Alarm SPH work process 2.04c MHP Activation Process - To guide staff on the appropriate process of activating Massive Haemorrhage Protocol (MHP) at Sunnybank Private. SPH Blood fridge maintenance and incident escalation protocol 5/21 The systems and processes are based on best practice guidelines and industry standards supporting clinicians to deliver blood management. Risks are managed through the risk register with regular reviews conducted to ensure appropriateness. Risk #17116 Provision of blood transfusion consent and risks information Risk #2042 Blood or Blood Product/component - incorrect product Risk #13926 Blood Safety -inadequate management of Training is completed via an eLearning platform and monitored via ELMO Dashboard. Evidence was sighted that ongoing education is provided to staff with current eLearning and competencies compliance at 79.08% with a continued positive trend noted.

Rating
Met
Findings
-

Action 7.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Evidence Reviewed
Monitoring the performance of the blood management system is conducted through the MARS auditing schedule. Dashboard #298 Blood and Blood Products Fridge and Register audit Quarter 2 2024 97 % compliance achieved. Dashboard #297 Appropriate use of Blood Management audit 94 % achieved. There is a blood fridge maintenance record with daily, weekly alarm check in place which is monitored by the Hospital Nurse Coordinator (HNC) to ensure the cold chain management process is maintained. The Hospital HNC also monitors the Massive Haemorrhage Drug Box contents with records maintained. Implementing strategies to improve blood management and associated processes was evidenced through the quality action plans #15524 completion of blood transfusion documentation and quality action plan #13890 increase blood safe education in the PACU which was completed 07/24 with 100 % completion reported. Reporting on the outcomes of blood management occurs through the Standard 7 Blood Management Meeting with minutes sighted 18/06/2024 and 20/08/2024.
Rating
Met
Findings
-

Action 7.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this and patients reported that they felt actively involved and informed about their care. There is a separate blood consent for blood and blood products in place with patients receiving an information brochure to assist with decision making. The Australian Red Cross consumer brochure- Australian Red Cross Lifeblood Receiving a Blood Transfusion is used to achieve this.
Rating
Met
Findings
-

Action 7.04
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Evidence Reviewed
It was observed that clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products. Optimising patients' own red cell mass, haemoglobin and iron stores is undertaken by Visiting Medical Officer (VMO) who prescribe iron supplements and Iron infusions as required. Ordering of blood and blood products is at the discretion of the VMO and is primarily driven on patients presentation and clinical assessment. During the time out process there is provision for the team to identify patients at risk of bleeding and this is an inclusions of the surgical safety checklist. Determining the clinical need for blood and blood products, and related risks is again at the discretion of the VMO and is documented in the patients medical records.

Rating
Met
Findings
-

Action 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Evidence Reviewed
Medical record review provided evidence that clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record (UR #328205).The use of the blood and blood products prescription and transfusion record HMR 10.8 assists staff with the action.
Rating
Met
Findings
-

Action 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Evidence Reviewed
Sunnybank Private Hospital has processes in place to support clinicians in the safe and appropriate practice of prescribing and administering blood and blood products. Medical record review provided evidence that clinicians prescribe and administer blood and blood products appropriately in line with the facilities policy (UR #328205). The use of the Blood and blood products prescription and transfusion record HMR 10.8 assists staff with the action. Evidence was sighted that ongoing education is provided to staff with current eLearning and competencies compliance at 79.08% with a continued positive trend noted. The National Blood Authority, Single Unit Transfusion Decision Support Tool is available to clinicians.
Rating
Met

Findings
-

Action 7.07
The health service organisation uses processes for reporting transfusion- related adverse events, in accordance with national guidelines and criteria
Evidence Reviewed
Sunnybank Private Hospital has processes in place for reporting of transfusion-related adverse events which are consistent with national guidelines and criteria. RiskMan is utilised to report all incidents inclusive of transfusion- related adverse events with further reporting requirements to the TGA outlined. This process is outlined in the policy, 8.64 Blood Transfusion -Management of Patient, Blood and Blood Products 09/23.
Rating
Met
Findings
-

Action 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Evidence Reviewed
Hemovigilance activities are conducted through Queensland Health and are consistent with the national framework. Blood wastage is reported and monitored through to the Standard 7 Blood Management Meeting with minutes sighted 18/06/2024 and 20/08/2024.
Rating
Met
Findings
-

Action 7.09
The health service organisation has processes: a. That comply with manufacturers' directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Evidence Reviewed
Sunnybank Private Hospital together with the Pathology companies Sullivan Nicolaides Pathology (SNP) and Queensland Medical Laboratory (QML) pathology has processes in place to comply with manufacturers directions and be able to trace blood and blood products from entry into the facility to transfusion, discard or transfer back to the pathology company. Evidence was sighted during the assessment that cold chain management records are maintained together with the blood register. The blood fridge S/N #LW25072254 was last serviced by CSK Group dated 04/07/2024.
Rating
Met
Findings
-

Action 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Evidence Reviewed
Sunnybank Private Hospital has processes in place to manage the availability of blood and blood products, eliminate waste and respond in times of shortage through 24 hour access to the pathology companies. The facility eliminates avoidable wastage by stocking only four units of 0 negative blood with monitoring of the expiry date and if not used returning to the pathology company. This process was confirmed in the review of the Blood register and through discussions with staff. QML Pathology blood wastage report SPH data 2024 Q1 (Jan- March) Issued to Transfused (IT) ratio = 1.8 recommended ITR >1.8. The policy 8.64a Blood Fridge Management and Unused Blood Products 11/20 outlines the management of the blood fridge and unused blood products.

Rating
Met
Findings
-

Action 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Evidence Reviewed
Healthscope has implemented a number of Corporate Policies for recognising and responding to acute deterioration with some local site policies implemented to support the various specialities. Healthscope policies include but are not limited to: - 8.13 Advanced Life Support - Adult - 8.88 Management of Anaphylaxis - 8.42 Basic life Support (BLS) and Cardiopulmonary Resuscitation (CPR) - 8.45 Recognising and Responding to Clinical Deterioration - 13.06 Advanced Life Support Paediatrics (PALS) - 13.01 Paediatric Patients - Admission and Care Risks included in the facility Risk Register include, #12020 Clinical deterioration – delay or failure to call a rapid response, #12021 Clinical deterioration-inadequate medical record documentation and #13931 Patient clinical deterioration - inadequate management of. These risks are scheduled to be reviewed 3-6 monthly. Advanced life support (ALS) training for staff working in the ICU who attend MET Calls is currently 84% with three staff overdue for the training. Paediatric advanced life support (PALS) is currently at 63% with eight staff yet to finish the training. The newly appointed NUM is working toward full compliance. A mock Code Purple was attended 29/2/2024 and mock Code Black on 22/8/2024.
Rating
Met

Findings
-

Action 8.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Evidence Reviewed
Monitoring of the recognition and response systems is via two means, firstly the internal audit schedule and secondly through the ICU and Resus Committee meetings. Minutes were provided from 29/7/2024 which demonstrated an overarching discussion of each of the 13 actions in this Standard, strategies to improve compliance and reporting of collected data. Data included MET Call numbers and outcomes, Hospital Acquired Complications (HACS) and ACHS Benchmarking data for unplanned readmissions within 24 hours. Staff were surveyed on clinical deterioration with overall feedback as positive. 91% of responses noted staff feel empowered to initiate a Met call, 88% feel confident in participated in a MET call and 73% were aware of the medical record documentation requirements.
Rating
Met
Findings
-

Action 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Clinicians actively involve patients in their own care and have a focus on inclusion and shared decision making, ensuring that the patient can comprehend the information being shared and this was observed during assessment. The patient experience surveys provides SPH with data on patient's involvement

in clinical decision making as one aspect of their episode of care and is reported throughout each department via Safety and Quality Boards with the Hospitals overall Safety and Quality Board recording a 78.5% rating. Patients were observed to be involved in Clinical Bedside Handover utilising ISBAR and reported to the assessor that they felt involved in their care and decision making.
Rating
Met
Findings
-

Action 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
Evidence Reviewed
Sunnybank Private Hospital processes enable clinicians to detect acute physical and physiological deterioration by accurate documentation and the monitoring of vital signs. Individual patients are monitored by their own monitoring plan formulated, reviewed, and changed as required. There is an opportunity for improvement to ensure trending of the observations recorded on the Observation and Response Charts is consistently completed across all areas of the hospital.
Rating
Met
Findings
-

Action 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan

c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported

d. Determine the required level of observation

e. Document and communicate observed or reported changes in mental state

Evidence Reviewed

Clinicians monitors performance of the identification and management of acute physiological, mental status, pain and / or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the assessment team. Discussions included the process for escalation of care where needed. Documentation was reviewed including policies and procedures that support the clinical staff to escalate care in response to clinical deterioration. The interventions are actioned in consultation with the treating team.

Noted that the ICU observations charts do not have patient triggers documented. A monitoring plan is set for each patient considering their diagnosis by the intensivist responsible for their care.

Staff assess mental state prior to admission and decide the frequency and type of monitoring accordingly. All actions are documented in the medical record.

Rating

Met

Findings

-

Action 8.06

The health service organisation has protocols that specify criteria for escalating care, including:

a. Agreed vital sign parameters and other indicators of physiological deterioration

b. Agreed indicators of deterioration in mental state

c. Agreed parameters and other indicators for calling emergency assistance

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

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

Evidence Reviewed

Policies, protocols, and clinical documents identify and include triggers for escalating care including vital sign, pain, distress, and clear parameters for initiating a MET call.

Rating
Met
Findings
-

Action 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Evidence Reviewed
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Assessors observed "Escalation of Care" posters in all patient rooms and clinical waiting areas.
Rating
Met
Findings
-

Action 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Evidence Reviewed
The facility has processes in place to escalate care and/or initiate any emergency response. Clinicians are well trained with management plans and policies in place. Equipment and emergency trolleys are standardised with checklists records maintained. All emergency trolleys in the hospital were noted to have up to date and complete checklists attached.
Rating
Met
Findings
-

Action 8.09
The workforce uses the recognition and response systems to escalate care
Evidence Reviewed
Escalation of care processes and procedures are in place, known by staff and used as necessary. ICU/Resus Committee Meetings. Last minutes from the ICU and Resus Committee 29/7/2024 note 60 Met calls for the period.
Rating
Met
Findings
-

Action 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Evidence Reviewed
Timely response of MET calls are measured and reviewed after every response with all responses entered into RiskMan and are subject to investigation and reported through the Committee Structure. There is a medical officer on site at all times. The facility has a Hospital Nurse Coordinator rostered on duty at all time with ALS and PALS training. A MET call occurred during the assessment. The patient's medical record was reviewed after the event with careful documentation included. Staff were observed to move quickly and calmly to the room.
Rating
Met
Findings
-

Action 8.11
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support

Evidence Reviewed
Deterioration in the physiological and mental state of the patient is consistently managed with appropriate policies and procedures available on the facility intranet. SPH has an ICU with a number of staff trained in ALS and PALS . There is a medical officer on site at all times. The facility has a Hospital Nurse Coordinator rostered on duty at all time with ALS and PALS training.
Rating
Met
Findings
-

Action 8.12
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
Evidence Reviewed
There are processes in place to ensure timely referral to mental health services. There is a credentialled psychiatrist and psychologist available to SPH in the event of an acute deterioration. Four transfers out for higher psychiatric care were reported in the minutes of the ICU and Resus Committee for the period.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Evidence Reviewed
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. The facility has the capacity to transfer patients to ICU. Staff were able to explain these processes to members of the Assessment Team. All deteriorating paediatric patients are transferred out. The majority of palliative patients are transferred for higher levels of care. Cardiac patients are transferred to specialty facilities.

Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable