Report of the ACHS National Safety and Quality Health Service (NSQHS) Standards Survey

Bellbird Private Hospital

Blackburn Sth, VIC

Organisation Code: 22 18 84

Survey Date: 30-31 January 2018

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:

The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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About The Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The ACHS was established in 1974 and is the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations.

The ACHS mission is to 'improve the quality and safety of health care' and its vision is 'to be recognised nationally and internationally as the leading Australian organisation that independently assesses performance and promotes and improves the quality and safety of health care.'

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

Accreditation is a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement of accreditation standards by a health care organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

How to Use this Survey Report

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

- provide feedback to staff
- identify where improvements are needed
- compare the organisation's performance over time
- evaluate existing quality management procedures
- assist risk management monitoring
- highlight strengths and opportunities for improvement
- demonstrate evidence of achievement to stakeholders.

This report provides guidance for ACHS members for future quality improvement initiatives by documenting the findings from the organisations accreditation survey. This report is divided into five main sections.

1 Survey Team Summary Report
2 Actions Rating Summary Report
3 Recommendations from Current Survey
4 Recommendations from Previous Survey
5 Standards Rating Summary Report

1 Survey Team Summary Report

Consists of the following:

Standard Summaries - A Standard Summary provides a critical analysis for organisations to understand how they are performing and what is needed to improve. It provides an overview of performance for that Standard and comments are made on activities that are performed well and indicating areas for improvement.

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.

The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review.

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve.

Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on-site survey.

Risk ratings and risk comments will be included where applicable. Risk ratings are applied to recommendations where the action rating is Not Met to show the level of risk associated with the particular action. A risk comment will be given if the risk is rated greater than low.

Risk ratings could be:

- E: extreme risk; immediate action required.
- H: high risk; senior management attention needed.
- M: moderate risk; management responsibility must be specified.
- L: low risk; manage by routine procedures

2 Actions Rating Summary Report

This section summarises the ratings for each action allocated by an organisation and also by the survey team.

3 Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.

Recommendations are structured as follows:

The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the survey team regarding progress in relation to those recommendations are also recorded.

The action numbering relates to the month and year of survey and the action number. For example, recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1.

5 Standards Rating Summary Report

This section summarises the ratings for each Standard allocated by the survey team.

Organisation : Bellbird Private Hospital
Orgcode : 221884

Survey Report

Survey Overview

Bellbird Private Hospital (BPH) is a forty-three (43) bed hospital owned and operated by Healthscope Ltd and provides medical, surgical, day procedure services and specialist consulting suites on site.

Led by a dedicated and committed executive team it was evident care and services are delivered safely.

The surveyors extend their thanks to the Executive, managers and staff for their active participation during the survey.

The newly appointed Consumer Consultant (CC) is very engaged and her contribution to the hospital's quality improvement program was clearly demonstrated and extremely valued.

The surveyors appreciated the wealth of information provided prior to the survey and at the time of the survey. Evidence was available to support the hospitals self-ratings of Satisfactorily Met (SM) in all National Safety and Quality Health Service Standards (NSQHSS) Core Action Items.

Significant progress has been achieved in relation to the developmental actions and the two (2) prescribed actions, Training in Aseptic Technique and Basic Life Support. The transitional Actions 3.10.1 and 3.16.1 have been met.

Quality and Safety Action Plans, staff education and training, as well as competency assessments are also in place to address ongoing areas for improvement. Review and evaluation of key indicators and projects is occurring.

Over recent years the hospital has had challenges in relation to occupancy and maintaining the level of skilled staff to support business activity in a small private hospital.

Following a Strategic Planning Conference in 2016 coordinated by the General Manager of the three (3) Eastern Group Healthscope (HSP) hospitals, Knox Private a 359-bed tertiary facility, Ringwood Private seventy-five (75) beds and the Victorian Rehabilitation Hospital, a decision was made to share resources from Knox Private for clinical services for example, Education, Allied Health and Pharmacy, as well as non-clinical services such as; Finance, Supply and Work Health and Safety. At the time of the survey, the surveyors were provided with well documented information demonstrating support that the strategic partnership is working well and staff were very positive about the ongoing collaborative arrangements.

Major changes to the quality KPIs at corporate level have also been implemented in September 2017. Defining the four (4) pillars of priority these are, Quality Clinical Outcomes, Exceptional Patient Care, Creating Extraordinary Teams and Delivering Market Lead Financial Returns. The executive and staff at BPH have embraced the future direction of Healthscope (HSP) and welcome the changes.

Overall Summary

BPH has a comprehensive clinical and corporate governance structure with robust systems to manage quality and risk. The information is well documented and provides evidence of indicators and outcomes to measure and improve performance.

Clinical practice is evidence based and staff clearly understand their responsibilities. There are mechanisms in place to support the early identification, intervention and management of patients at increased risk of harm with relevant and appropriate systems to escalate the level of care in the event of unexpected deterioration.

The patient clinical record is well integrated and appropriate to good patient care.

Credentialing and scope of practice is managed in accordance with HSP policies and By-laws.

Performance and skills management is well done with appropriate systems in place to support, monitor and evaluate performance across all disciplines.

Staff education and training in respect of patient safety and quality is comprehensive.

The system for managing incidents and complaints is effectively managed across the hospital. Open disclosure policies and processes are in place and the clinical workforce has been trained.

Patient's rights and responsibilities are well respected and included in information compendiums, brochures, the website and at the point of care.

Consumer participation is actively sought. The engagement of patients' families and carers in activities that improve safety and quality was evident. The Consumer Consultant has provided a great deal of suggestions for improvement at all levels.

Preventing and Controlling Healthcare Associated Infections is well embedded in every day practice in all clinical units and support services. Whilst the hospital is ageing, it is impeccably clean, tidy and well maintained. The low infection rate is testament to the efficacy of the systems. The transition to AS/NZS 4187:2014 is proceeding and plans to refurbish the CSSD are underway.

There are established processes in place to manage medication safety. Documentation of patient information, continuity of medication management and the reconciliation of medicines are audited regularly with good results.

Patient identification and procedure matching, transfer of care and matching of patients and their care are well documented and audited for compliance at every point of care of the patient's journey.

Clinical Handover is outstanding with good local processes developed in collaboration with clinicians, patient and carers. The information on the electronic whiteboard is very impressive.

Blood management systems and blood product transfusions are safe, appropriate, effective and efficient.

Comprehensive strategies and procedures for preventing and managing pressure injuries are well documented and are reflected in the excellent results.

Skilled, caring and responsive staff are extremely well educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient's health status.

Preventing falls and harm from falls is reported and managed diligently with good patient outcomes noted.

BPH should be proud of their good work, their innovation and their achievements in improving care and services.

Further comments and suggestions for improvement have been included in the Standard Summaries.

Organisation : Bellbird Private Hospital
Orgcode : 221884

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Bellbird Private Hospital (BPH) has a well-defined corporate and clinical governance structure appropriate for the range of services provided by the hospital. Clinical and support staff involvement in safety, quality and risk management is clearly demonstrated.

There is a range of Healthscope (HSP) corporate and cluster policies and procedures in place, along with local polices as deemed applicable. There has been some very good work in relation to the standardisation of policies across all services, fifty (50) in total, as well as the reduction of local policies that are specific to the needs of the hospital to eight (8). The Governance audit in 2017, with review of local policy and distribution of corporate policies achieved 100%.

There is a document control system whereby all policies are kept up-to-date and are readily available to all staff. Whilst the staff have access to all policies on the intranet and hard copy, it is suggested that the hospital may review the list of “high risk” policies and have those policies more easily accessible if the need arose. Legislative changes are monitored at corporate level and the hospital is informed of any changes that may be required. There is a strategic plan which is reviewed on an annual basis. This has been a decision by BPH due to the changing dynamics and demographics of their location.

The HSP Clinical Governance Framework 2017/2018 forms the basis in decision making and this is evident in the strategic and business plans for the hospital.

The hospital’s organisation and committee structure supports the overall governance of BPH. The formation of the “Knox Group” and the sharing of key personnel and clinical disciplines has had a positive impact not only in regard to the financials but the support and sustainability of the workforce.

The surveyors acknowledge the good work undertaken by the Quality Manager and the committee to review the timeliness and relevance of audits and to clearly focus on outcomes and areas for improvement. It has been suggested that an audit of the Comprehensive Nursing Management Plan be included in the audit schedule to ensure the compliance to documentation is being achieved.

The Medical Advisory Committee (MAC) is actively involved in all aspects of clinical care. The information provided to the members, particularly the comprehensive clinical indicator set is well documented and reflects the hospitals clinical performance. For example, credentialing, infection control, morbidity and mortality, risk and adverse events are all standard agenda items. In addition to ACHS Quality indicators, the hospital participates in benchmarking activities with similar peer group hospitals within the HSP group. BPH results are in the top rankings which are to be congratulated.

Staff are aware of their roles and responsibilities in all aspects of quality and safety. Position descriptions and annual performance reviews are conducted. Workforce planning, performance management and education are of high priority. Review and evaluation is occurring at all levels.

Staff orientation is provided at the commencement of employment and has been extended to meet the needs of the new employee. The mandatory training schedule is comprehensive and incorporates eLearning packages (ELMO), face-to-face education and training, as well as competencies applicable to the specific disciplines. The monitoring and diligent management of the education program is highly impressive on average over 90% compliance has been obtained in all the mandatory topics, a significant achievement.

The survey team also noted the wide range of topics on the mandatory training agenda. This is currently being reviewed in the aim to reduce timeframes for staff to complete and ensure the topics are relevant to the specific services.

The risk register is managed by the hospital and clearly identifies clinical safety, financial and occupational health and safety risks. The register is a working document and is monitored and reviewed regularly. Each identified risk has a risk rating and linked to a mitigation strategy.

The hospital's organisational wide quality improvement system is led by the Quality Committee.
The extensive suite of indicators is well documented and reports are discussed at the committee and department level and reported to corporate. The committee also reviews the quality action plans of the hospital.

Clinical practice

Clinical services and procedures are governed by a raft of best practice clinical guidelines. Compliance is monitored through rigorous reporting of adverse events, near misses, results from audits, patient complaints and feedback. There are validated risk assessment tools used for assessing all patients on admission. Those deemed "high risk" or at risk of harm are then subject to further screening and assessment. Benchmarking occurs at peer group level and monitored by the cluster committees. Serious breaches are reported to HSP. It is pleasing to note that BPH has nil breaches in this regard.

There are clear exclusion criteria and guidelines that outline the procedures that can be performed safely and within the clinical capabilities of the hospital. If, however, there is an unexpected deterioration in a patient's health status there are well qualified medical and nursing staff available to assist. Emergency support is provided by the ambulance service and there are good relationships established with Knox Private and Box Hill Public Hospital if the need arises.

The surveyors did raise the exclusion age policy for paediatrics and whether this policy applies to paediatric admissions at the hospital due to the low number of children admitted, the type of procedure and the extent of resuscitation training required. This issue is on the risk register and surveyors sighted the agenda and revised draft amendments to the current policy which is for discussion at the next MAC meeting in early February with a view to amend the current policy to raise the age to fourteen (14) years and over. Comments are also noted in the Standard 9 Summary.

The patient's medical records are well collated and managed in accordance with relevant standards and guidelines. Colour coded standard forms and dividers certainly make it easier for staff and VMOs to find information within the record. Specific medical record forms and charts are in every room, this has improved the timely access to information by the clinical staff especially in regard to the signing of telephone orders by the doctors.

Various documentation audits are conducted to address compliance. It has been suggested that the hospital undertake an internal audit in relation to the use of abbreviations such as Left and Right to ensure this is meeting the policy.

Clinical coding is of high priority and is a project across all HSP facilities. The surveyors were impressed by the importance the hospital has placed on the accuracy and documentation of clinical notes. Casemix meetings are held regularly using a comprehensive casemix template which has all current patient details including Diagnosis Related Groups (DRGs). This allows the Health Information Manager (HIM), executive and clinical managers to quickly identify any discrepancies as well as Length of Stay (LOS) outliers. If required, education can be actioned in a timely way either by "Huddle Sessions" or further audits.

Performance and skills management

All Visiting Medical Officers (VMOs) appointed to the hospital are subject to the HSP credentialing process and a defining of their specific scope of clinical practice. The credentialing procedure is clearly outlined in schedule five (5) in the HSP By-laws. The new e-Gov credentialing system enables the medical staff and allied health professionals the ability to go online and register their application and or re-credentialing requirements. HSP and the hospital are now able to review these applications remotely. This system overtime will eliminate the need for a paper-based system.

New appointments and re-appointments are reviewed by the MAC along with any new procedure. Information on the scope of practice is also made available to key members of the clinical staff and Operating Theatre Manager.

Members of the nursing and allied health staff have their scope of practice defined in their position descriptions or contracts. Staff appraisals include competencies and are conducted annually measured by a number of performance indicators applicable to the employee's role.

Incident and complaints management

Incidents and complaints are reported and recorded on RiskMan, the incident management system. Information is provided to the management and staff, the MAC and to HSP. Significant results or events are also published on Shared Learnings which is a very constructive way of disseminating outcomes and lessons learnt to the staff.

An open disclosure policy is in place. If an event occurs that requires such disclosure, support from HSP is readily available to assist the management and staff.

Patient rights and engagement

The National Charter of Patient Rights and Responsibilities is well displayed throughout the hospital. It is included in the patients' admission pack and features on the hospitals new DVD TV presentation which is a great initiative.

Patients are actively involved in their care and consent for procedures well explained and documented. Consent processes include clinical consent and informed financial consent. Interpreter services are available if the need arises. Feedback is also gained from the patient experience and Patient Centered surveys.

BPH is a relatively short stay medical and surgical hospital with a busy Day Surgery Unit.

If an Advanced Care Directive is warranted, this is referred back to the patient's General Practitioner. There are also policies and procedures and alert systems relating to Not-for-Resuscitation (NFR) orders if applicable.

Privacy and confidentiality is managed well and all staff are aware of their responsibilities.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	SM	SM
1.3.1	SM	SM
1.3.2	SM	SM
1.3.3	SM	SM
1.4.1	SM	SM
1.4.2	SM	SM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	SM
1.6.2	SM	SM

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.1	SM	SM
1.7.2	SM	SM
1.8.1	SM	SM
1.8.2	SM	SM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM

1.10.3	SM	SM
1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	SM
1.14.3	SM	SM
1.14.4	SM	SM
1.14.5	SM	SM
1.15.1	SM	SM
1.15.2	SM	SM
1.15.3	SM	SM
1.15.4	SM	SM
1.16.1	SM	SM
1.16.2	SM	SM

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM
1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The hospital is supported by a range of HSP and BPH policies, procedures and protocols specific to partnering with consumers. The 2016 HSP policy 'Partnering with Consumers' provides clear expectations and guidance on how to engage with consumers and the level of involvement they have in terms of operational and strategic planning. This is also supported by a HSP consumer engagement plan 2016-2019.

BPH appointed a Consumer Consultant (CC) in early 2017. There is a consumer consultant position description and orientation program that articulates responsibilities. It was clearly evident when talking with the consumer consultant, her understanding of her role. The consumer consultant meets regularly with the Quality Manager to discuss responses to patient's visits using a very simple questionnaire. The consultant also attends and participates at the Quality Committee meetings in regard to strategic and operational business planning, quality and risk data, education for staff and patients, patient surveys, consumer brochures and environmental risks.

There is also a feedback form which has now transitioned to an electronic form. Every patient who has provided an email address is automatically sent a feedback questionnaire to complete. BPH has experienced an increase in response rate in their patient experience survey since the electronic form has been introduced in 2017. Results are extremely complimentary.

Consumer partnership in designing care

In the short time since the Consumer Consultant has been appointed, there has been some very good suggestions and constructive evaluation of services provided. Patient visits have been well received. The (CC) will be actively involved in the annual strategic planning days in the future which will include any design and redesign of the hospital and services.

Consumer partnership in service measurement and evaluation

MyHealthscope and MyHospital websites provide clinical outcome data to the general public, for example, falls and pressure injury rates, hand hygiene compliance and unplanned re-admission. There is evidence that the CC participates in the analysis of quality and safety data and consumer feedback on a regular basis. Improvements in service provision are evident as a direct result of CC feedback, for example, changes to the hand basin taps to make them easier for patients to turn on and off; the menu has been revised to accommodate more choices and education for staff implemented.

The surveyors were impressed by the commitment and engagement of their Consumer Consultant thus far; however, it is a lone role and have suggested she attends the "Knox Group" Consumer Group where experiences can be shared and discussed in a broader forum.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	SM
2.1.2	SM	SM
2.2.1	SM	SM
2.2.2	SM	SM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	SM	SM

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	SM	SM
2.8.2	SM	SM
2.9.1	SM	SM
2.9.2	SM	SM

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

The hospital has in place effective infection prevention, control and surveillance governance structures that are evidence based and in line with relevant legislative requirements. An Infection Control Plan for the hospital is managed by an Infection Control Coordinator with support from Healthcare Infection Control Management Resources (HICMR) consultants. The plan is reviewed and updated annually by the hospitals Infection Control Coordinator and HICMR consultant. A range of policies and procedures are available on line to guide staff and HICMR consultants are available 24-hours a day seven-days a week. An Infection Control Committee provides oversight and monitoring of audit results and areas of non-compliance. Minutes of Infection Control meetings were reviewed at survey and demonstrated the reporting of performance outcomes, issues and actions. Minutes are tabled at the Medical Advisory Committee (MAC) and quarterly reports are forwarded to the National Quality Committee for review. A comprehensive surveillance program is in place and supports the identification, escalating and reviewing of healthcare associated risks. Critical system reviews are undertaken on cases requiring review/intervention and education is provide.

Infection prevention and control strategies

The hospital has in place a comprehensive Hand Hygiene Program. Hand Hygiene education is provided to all employed staff at orientation and as part of the annual mandatory training with a 94% compliance rate. At survey, the surveyors were able to see hand sanitising gel available for staff, carers and visitors. Hand Hygiene compliance against the 5 moments is collected and displayed on the MyHealthscope website with the latest audit demonstrating a whole of hospital compliance rate of 85%. Strategies are in place to improve compliance, for example targeted signage and education.

A workforce immunisation program that complies with national guidelines is in place. A qualified Immunisation Nurse is on staff. Staff are required to complete a pre-employment vaccination assessment form that is reviewed for compliance to the guidelines and actioned if required. A recent audit of the staff database recording immunisations has been undertaken to ensure the maintenance of the records being held is correct. The hospital also provides an annual Influenza Vaccination Program.

As part of the orientation program all staff receive education on avoiding and managing occupational exposures and the correct use of Personal Protective Equipment. Any incidents of occupational exposure are recorded in RiskMan and allows for notification, trending and further action if required.

The catering department undertakes the Food Safety Program and a 2017 local council review of the kitchen and catering processes resulted in a 5-star rating.

A range of policies support compliance with best practice in the management of invasive devices and the prevention and controlling of infections. Aseptic Technique eLearning is an annual mandatory competency for all employed clinical staff with a 95% compliance rate for the education and competency completion. Aseptic technique training guides and resources are available within the clinical area. Compliance with aseptic technique is audited by the Infection Control Coordinator. The transitional arrangements for aseptic technique (Action 3.10.1) have been met.

Managing patients with infections or colonisations

Effective policy and procedures are in place to support staff in the appropriate management of patients with infections and/or colonisations. Standard and transmission based precautions are well established and observational auditing demonstrated 100% compliance with appropriate signage and 94.4% compliance rate for availability of personal protective equipment. Regular auditing, as viewed on the audit schedule at time of survey, monitors compliance with policy/procedure/protocol. Any areas of non-compliance are corrected and recorded in RiskMan and used as shared learning's. Environmental cleaning processes are audited as part of HICMR's risk assessment program. Educational information on managing infection is available within the clinical area for staff, patients and carers. Systems are in place as part of the pre-admission process to risk-assess patients for appropriateness of admission. The hospital has access to an Infectious Diseases Physician to assist in the management of patients with infections or colonisations. Information on patient's infectious status is transferred as part of clinical handover.

Antimicrobial stewardship

An effective antimicrobial stewardship program is in place. The program has Pharmacist, Clinical Microbiologist and Infectious Diseases Physician input. Auditing of antibiotic usage is undertaken with reports being tabled at the Knox/Bellbird Antimicrobial Stewardship meeting and the Medical Advisory Committee. A traffic light system is in place for antibiotic usage with antibiotics on the red list only being dispensed for 72 hours unless a review from the Infectious Diseases Physician is undertaken and confirms ongoing usage. Hard copies along with electronic copies of the current endorsed therapeutic guidelines on antibiotic usage are available in all clinical areas. Monitoring of antimicrobial usage and resistance via laboratory based data is undertaken by the Infection Control Coordinator and HICMR consultant. The Pharmacist maintains data on antibiotics prescribed. The hospital celebrates Antibiotic Microbial Awareness week in November each year where educational material is displayed to the clinical staff, patients and carers.

Cleaning, disinfection and sterilisation

An established environmental cleaning schedule is in place with cleaning audits regularly undertaken. All clinical areas were observed to be clean and well maintained. A Waste Management Plan is in place and storage of waste was viewed at survey. An audit schedule is in place to ensure High efficiency particulate air (HEPA) Filter maintenance is undertaken and 2018 results were sighted. Linen is provided by an external provider and processes viewed at survey for the collection of dirty linen and delivery and storage of clean linen demonstrated good practices. Disinfectant wipes were available within the clinical area and staff were able to articulate to surveyors when they were used. HICMR consultants undertake Environmental Services Risk Assessment reviews with results being given to the Environmental Services Manager and tabled at the Infection Control Committee. Reprocessing of reusable medical equipment, instruments and services meets the requirements of AS/NZS 4187:2014. Reprocessing of endoscopes meets Gastroenterological Nurses College of Australia (GENCA) guidelines. CSSD technicians hold appropriate sterilisation certificates. An instrument tracking system is in place for reusable instruments.

An extensive gap analysis against AS/NZS 4187:2014 has been undertaken by HICMR and the hospital. The risk rated action plan is a work in progress and the Healthscope National Quality Committee receive quarterly reports on the progress being made. As part of the AS/NZS 4187:2014 action plan the hospital has undertaken an architectural review of the current peri-operative and CSSD space constraints and the recommendations from this report will be considered by Healthscope Board of Management as part of the actions to meet AS/NZS 4187:2014 in full. The hospital has satisfactorily demonstrated progress towards full implementation of AS/NZS 4187:2014 as detailed in their action plan.

Communicating with patients and carers

The hospital communicates with patients and carers via posters, brochures, information sheets and its website. A range of outcome indicators including Hand Hygiene and Infection rates are available on the website. The hospitals consumer representative spends time meeting and communicating with patients and carers.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	SM
3.1.2	SM	SM
3.1.3	SM	SM
3.1.4	SM	SM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	SM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	SM
3.10.2	SM	SM
3.10.3	SM	SM

Action 3.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The hospital, in conjunction with HICMR, has undertaken a comprehensive organisational risk analysis of aseptic technique competencies and has developed and implemented an annual mandatory aseptic technique eLearning training package and competency assessment for all employed clinical staff involved in patient care. Records viewed at survey indicate 95% completion rate of both education and competency.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM
3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM
3.13.2	SM	SM

Antimicrobial stewardship

Ratings

Action	Organisation	Surveyor
3.14.1	SM	SM
3.14.2	SM	SM
3.14.3	SM	SM
3.14.4	SM	SM

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Action 3.16.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A comprehensive gap analysis on the requirements of AS/NZS 4187:2014 has been undertaken by hospital staff and HICMR. A risk-rated, detailed implementation action plan, with timeframes has been developed and is a work-in-progress. A quarterly report on the status of deliverables on the implementation action plan is reviewed by the hospital and forwarded to Corporate Head Office.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation : Bellbird Private Hospital
Orgcode : 221884

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Medication Safety policies, procedures and protocols are in place and managed in accordance with National and Jurisdictional Legislative requirements.

Prescribing, dispensing, administration, storage and supply are all managed well.

Medication errors and adverse events are reported on RiskMan. The medication management system is regularly monitored by a range of activities and audits including the National Inpatient Medication Chart (NIMC) audit, the Medication Safety Self-Assessment (MSSA) and Ward Drug Audits. Medication incidents are discussed at the Pharmacy and Quality Committee, MAC and at Cluster level. BPH has continued to have a very low rate of medication errors. Staff are required to use an internally developed reflective practice tool if they are involved in any medication error incidents.

Hospital Pharmacy Services (HPS) Clinical Pharmacist is also actively involved in all aspects of medication safety.

Position descriptions include medication responsibilities and provide guidance on scope of clinical practice. A specific policy for medication endorsed enrolled nurses inclusive of IV medication administration is in place. Education is of paramount importance and a mandatory education module specific to medication management for registered and enrolled nurses ‘Med Safe’ is used. Also, this module is in the process of being updated to include more specific competencies applicable to the clinical staff’s roles and responsibilities regarding medication safety.

Documentation of patient information

A best possible medication history is obtained from all patients at the time of admission. A Medication Management Plan is used for all medical patients and surgical inpatients. The BPH Medication Reconciliation Flow Chart and Medication Management Plan include the medication reconciliation process on admission and transfer at the time of discharge.

Medication alerts and adverse drug reactions are recorded in the patient’s medical record and at the bedside. This is routinely audited and evaluated. As part of the admission, patients are required to complete a Patient Health History which also incorporates questions specific to medication management.

The Clinical Pharmacist is involved in this process which is well established and effective.

Medication management processes

There are a range of decision support tools and resources to support the clinical workforce at the point of care such as eMIMS and eTherapeutic Guidelines (eTG).

Internal monitoring systems and regular audits are conducted to review the secure storage and safe distribution of medicines throughout the hospital. The ward and theatre drug rooms were extremely well organised. High-risk, look-alike sound-alike medications, Dangerous Drugs Act (DDAs) and injectables were clearly labeled.

Receipt and disposal of unwanted and expired medications is managed by HPS throughout all clinical areas.

Temperature sensitive medications are monitored daily. A new medication fridge has been installed in the ward. It was noted at the time of the survey the theatres close on Friday evenings and do not re-open until Monday. The surveyors have suggested that a system for monitoring the theatre fridge when unattended for this length of time be reviewed to ensure the efficacy of the drugs can be validated.

Continuity of medication management

The Clinical Pharmacist is actively engaged with patient's medication management.

Patient's current medications are recorded at the time of admission and documented on the NIMC and or Medication Management Plan by the clinical staff in consultation with the patient.

The Clinical Pharmacist provides medication profiles and education to patients if new medications have been prescribed or if medications have changed.

Medication reconciliation occurs at the time of discharge which is completed by the Clinical Pharmacist. A Medication Management Plan audit in 2017 achieved 96% compliance. A National Inpatient Medication Chart (NIMC) audit in November 2017 resulted in 83% compliance. From the result, the alert sheet is now kept at the point of care and improvements have been noted.

A nursing discharge summary created through WebPAS is a secondary source of relevant medication information that is provided to the receiving clinicians during clinical handover and upon discharge back to the General Practitioner.

Communicating with patients and carers

Patients, families and carers have the opportunities to discuss medications at any time with clinicians.

Purposeful rounding and bedside handover also provides the patient with further opportunities if they have concerns. Information booklets are provided and consumer medication information leaflets are available in the ward and day surgery and are given to patients on discharge.

All staff have access to HPS Pharmacy to seek advice and information if required.

The hospital's in-house DVD provides patients with information about medications and their role in medication safety. Feedback from patients is very positive.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	SM
4.1.2	SM	SM
4.2.1	SM	SM
4.2.2	SM	SM
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	SM	SM
4.4.1	SM	SM
4.4.2	SM	SM
4.5.1	SM	SM
4.5.2	SM	SM

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM
4.6.2	SM	SM
4.7.1	SM	SM
4.7.2	SM	SM
4.7.3	SM	SM
4.8.1	SM	SM

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM
4.10.5	SM	SM

4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	SM
4.12.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.13.1	SM	SM
4.13.2	SM	SM
4.14.1	SM	SM
4.15.1	SM	SM
4.15.2	SM	SM

Organisation : Bellbird Private Hospital
Orgcode : 221884

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The hospital requires four (4) patient identifiers to be used. All patients' details are verified on admission through WebPAS, the Patient Information System, whereby a unique identifier is generated. Duplicate numbers can easily be traced by running a report. All patients are required to wear a white wristband on admission and a red wrist band if alerts are identified.

Regular auditing is undertaken of compliance with identifying patients as per the patient identification and procedure matching policies.

Processes to transfer care

There are well structured processes in place that includes patient identification at every handover point from admission through to discharge. There have been no incidents or breaches that have occurred which is testament to the rigorous monitoring and compliance to patient identification.

Processes to match patients and their care

BPH has processes in place to correctly match patients to their care. Team Time Out is well established in the Theatre Suite with Medical Officers and staff well engaged in the process. Regular audits are undertaken to measure compliance. One hundred percent (100%) compliance was achieved in the latest audit in August 2017.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	SM	SM
5.2.1	SM	SM
5.2.2	SM	SM
5.3.1	SM	SM

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.1	SM	SM
5.5.2	SM	SM
5.5.3	SM	SM

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical Handover is managed well.

There is a raft of handover tools and checklists in place underpinned by comprehensive policies, procedures and audits. Clinical Handover incidents are reported and monitored at the local level and against HSP indicators.

Information about incidents relating to the handover process is shared with other similar hospitals to assist in ensuring improvements are applied to the procedure if deemed necessary.

Clinical handover incidents are rare at BPH.

Clinical handover processes

At every point of care there are systematic inter-departmental handover processes, checklists and discharge criteria. The ISBAR (Identify, Situation, Background, Assessment and Recommendation) tool has been adopted as the standard format for clinical handover.

A printed patient information sheet is available to staff members involved in handover. At ward level, handovers include an initial handover by the in-charge nurse followed by a handover by staff members caring for allocated patients. Bedside handover is conducted in the afternoon where each patient's care is discussed. This was verified during an observation visit and managed well. The patient and their relative also were very complimentary about the information provided. Allied health professionals and VMOs are clearly involved in handover.

Progress note entries are well documented allowing any clinician at any time to view the progress of the patient's care.

There are good relationships with Radiology and Pathology providers to ensure results are available in a timely manner.

Recent improvements include the electronic whiteboard at the nurse's station and a more detailed format of information in the bedside chart folders and on the white boards in each patient's room.

Patient and carer involvement in clinical handover

Active involvement of patients, families and carers was evident. There is a wealth of information on admission about handovers explaining the role of the clinician and the role the patients can play in their handover as they occur.

Patients are periodically asked for feedback regarding participation in their care, staff identification and communication. BPH has achieved a rating of over 90%.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	SM	SM
6.1.3	SM	SM

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.2.1	SM	SM
6.3.1	SM	SM
6.3.2	SM	SM
6.3.3	SM	SM
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	SM	SM

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Governance and systems for blood and blood product prescribing and clinical use

The Healthscope Blood Transfusion Cluster provides local governance for blood and blood product prescribing and clinical use and reports quarterly to the National Quality Committee. Healthscope's Joint Hospital and Pathology National Transfusion Committee supports communication between pathology providers and hospitals along with monitoring KPIs and practices. Auditing on the transfusion documentation, blood fridge, blood wastage and appropriateness of use of blood or blood products is undertaken.

Documenting patient information

The hospital has reviewed its blood and blood product documentation and introduced a new Blood and Blood Product Prescription and Management form. A range of evidence-based policies and procedures provide guidance to clinical staff on the management of blood transfusions. The patient's pre-admission health questionnaire seeks information on previous transfusion of blood or blood products and any reactions that occurred. A separate consent for Blood Transfusion Blood Product Administration is in place. Auditing of consent since 2016 indicates only one case where a consent form was not contained within the medical record.

Managing blood and blood product safety

The hospital has made improvements to its management of blood and blood products by reviewing its cold chain management and working in collaboration with the provider of blood ensuring that all blood deliveries are handed directly to a clinical staff member and the blood is checked into the blood fridge as per the policy. Auditing of the change to process has demonstrated 100% compliance of delivery of blood directly to the blood fridge.

The blood fridge is maintained by an external pathology company. A remote alarm is in place along with a temperature alarm to the nurse call bell system. Any incidents are recorded in RiskMan and reviewed. Clinical practice was changed after a blood transfusion incident recorded that a patient had developed a red rash on their chest during transfusion. All patients now have a skin assessment noting any rashes as a baseline prior to the commencement of the transfusion.

A blood resource folder is available in the clinical areas and all clinical staff undertake mandatory annual Blood Safe eLearning with a compliance rate of 88%.

The hospital has zero cases of wastage of blood or blood products.

Communicating with patients and carers

All patients receive a Blood Safe consumer brochure at the time consent is gained. The hospital’s consumer representative has reviewed the brochure for ease of understanding. Auditing of blood transfusions includes a criterion relating to patients having received the brochure. The patient and/or carer is also provided with information from the Australian Red Cross and the South Australian Blood Bank. Information on blood transfusion is also contained on the patient’s information TV channel.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and systems for blood and blood product prescribing and clinical use

Ratings

Action	Organisation	Surveyor
7.1.1	SM	SM
7.1.2	SM	SM
7.1.3	SM	SM
7.2.1	SM	SM
7.2.2	SM	SM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	SM	SM
7.6.1	SM	SM
7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	SM	SM
7.8.1	SM	SM
7.8.2	SM	SM

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	SM
7.11.1	SM	SM

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The hospital has evidence-based governance systems for the prevention and management of pressure injuries. The Healthscope Pressure Injury Prevention Cluster provides local governance with quarterly pressure injury KPIs being sent to the National Quality Committee. A suite of evidence-based policies are available to support and guide practice. Trended Clinical Indicator data on pressure injury is collected and discussed at the MAC and published on the hospital's website. Incidents of pressure injury are entered into RiskMan.

Preventing pressure injuries

Preventing pressure injuries commences with pre-admission screening for pressure injury status and is complemented by a pressure injury risk assessment on admission. The pre-admission clinic advises the ward of high-risk patients being admitted. Pressure injury risk assessments must be completed within 8 hours and audit results show 98% compliance. The hospital has a Wound Champion who drives pressure injury prevention and management and updates the pressure injury prevention resource file. A malnutrition screening tool forms part of the risk assessment that is undertaken. Auditing of completion of the form showed poor compliance at 31%. Targeted education by the dietician on the importance of completion of the malnutrition screening showed an improvement within three months to 76% compliance.

A restructure of patient bedside folders was also undertaken so all risk assessment documentation is kept at the point of care.

An audit schedule is in place to monitor and evaluate compliance and effectiveness of practice. The hospital has a comprehensive inventory of pressure injury prevention equipment available to assist in preventing pressure injuries.

Managing pressure injuries

Wound management practices are evidence based and staff have access to a Wound Consultant and a Dietician to assist in the management of pressure injuries. Patient Purposeful Rounding assists in the repositioning and/or moving of patients. Comprehensive nursing care plans document care and bedside handover includes a review of patient skin/pressure condition. Pressure Injury Prevention and Management eLearning is available for staff.

Communicating with patients and carers

The hospital's patient DVD TV channel provides information on pressure injury prevention and there is also written material to patients and carers on the prevention of pressure injuries. Pressure injury rates benchmarked against national targets are published on the hospital's website. An audit of patients in 2017 demonstrated that 75% of patients had received information on pressure injury prevention.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and systems for the prevention and management of pressure injuries

Ratings

Action	Organisation	Surveyor
8.1.1	SM	SM
8.1.2	SM	SM
8.2.1	SM	SM
8.2.2	SM	SM
8.2.3	SM	SM
8.2.4	SM	SM
8.3.1	SM	SM
8.4.1	SM	SM

Preventing pressure injuries

Ratings

Action	Organisation	Surveyor
8.5.1	SM	SM
8.5.2	SM	SM
8.5.3	SM	SM
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	SM	SM
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	SM	SM

Managing pressure injuries

Ratings

Action	Organisation	Surveyor
8.8.1	SM	SM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation : Bellbird Private Hospital
Orgcode : 221884

STANDARD 9
RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION IN ACUTE HEALTH CARE

Surveyor Summary

Establishing recognition and response systems

At a local level, the Healthscope Clinical Deterioration Cluster provides a governance system for the recognition and management of the deteriorating patient. The cluster reports to the National Quality Committee quarterly on a range of clinical deterioration KPIs. Evidence-based policies and procedures provide support and guide the recognition and response systems for deteriorating patients. The Medical Emergency Management Policy has recently been reviewed and the clinical deterioration rapid response system is in alignment with the national standards guidelines. All incidents of clinical deterioration are entered into RiskMan with a monthly report and trend report reviewed by the hospital's Quality Committee. Pre-admission screening of patients identifies patients with conditions on the hospital's admission exclusion list, for example BMI of 40 or above. All transfers out and unexpected deaths are reviewed by the MAC.

Recognising clinical deterioration and escalating care

Track and trigger observation charts are in place which provide colour coded trigger ranges that identify a clinical review or if a rapid response is needed. Regular audits of the observation charts for completion and escalation are conducted with 100% of observation charts having appropriate escalation for all observations outside the white area. The hospital has a low monthly number of incidents of deteriorating patient; however, at the time of survey a MET (Medical Emergency Team) call was made and surveyors were able to witness the arrival of staff and activation of rapid response as per the hospitals policy. Fortunately, the patient recovered and did not need to be transferred out.

All patients have a full set of observations taken as part of the handover of care. Patients transferred out for higher level care are entered into RiskMan, reviewed by the senior management team and forwarded to National Quality and Safety Committee as part of the quarterly quality KPI reviews.

Responding to clinical deterioration

The employed clinical workforce undertakes mandatory basic life support training on an annual basis and 96% of the employed clinical workforce having completed both the theory and practical component. Clinical staff who do not complete their training are not eligible to work until the education and competency are completed.

The transitional requirements for basic life support (Action 9.6.1) has been fully met. The hospital has reviewed its admission exclusion policy. Currently, the hospital accepts paediatric patients from six years of age. A quality improvement project reviewing the clinical needs of the deteriorating paediatric patient has resulted in a recommendation to raise the admission age to 14 years. The draft policy with changes was noted on the February MAC agenda for endorsement.

Advanced Care directives are in place and supported by policy. Auditing of Advanced Care Directives is undertaken.

Communicating with patients and carers

At the time of admission, the hospital provides patients and their families/carers with an escalation of care brochure that explains how to escalate care. The escalation process is also detailed on the patients care board which is located on the wall directly opposite the patient. At the time of orientation to the room the patient, family and carers are advised on how to escalate care. A 2017 audit undertaken by the hospitals consumer representative found 100% of family members/carers knew how to escalate care. The hospital has not received an escalation call and has therefore introduced an annual mock escalation of care. Using a patient's family member, a mock scenario is undertaken by hospital staff to ensure that the escalation process is robust and to identify any improvements needed. A debrief that includes the patient and family member is undertaken.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Establishing recognition and response systems

Ratings

Action	Organisation	Surveyor
9.1.1	SM	SM
9.1.2	SM	SM
9.2.1	SM	SM
9.2.2	SM	SM
9.2.3	SM	SM
9.2.4	SM	SM

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	SM	SM
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	SM	SM

Responding to clinical deterioration

Ratings

Action	Organisation	Surveyor
9.5.1	SM	SM
9.5.2	SM	SM
9.6.1	SM	SM
9.6.2	SM	SM

Action 9.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The hospital has undertaken a risk analysis of basic life support training needs and developed a plan that is contained in policy and documentation within the clinical area to ensure the clinical workforce can initiate early interventions and respond with life-sustaining measures. Training in basic life support is an annual mandatory competency for all employed clinical staff. At survey, evidence was provided of 96% compliance of staff completing the competency.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
9.7.1	SM	SM
9.8.1	SM	SM
9.8.2	SM	SM
9.9.1	SM	SM
9.9.2	SM	SM
9.9.3	SM	SM
9.9.4	SM	SM

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

A suite of best practice policies and guidelines are in place to assist staff in preventing falls and harm from falls. The Healthscope Falls Cluster reports to the National Quality Committee quarterly on Falls KPIs. All falls are recorded in RiskMan.

The hospital’s Quality Committee reviews all incidents of falls and falls data is trended month to month. A quarterly falls report on trended data is tabled at the MAC.

The hospitals rate of falls with an adverse outcome is low. A Falls Champion has been introduced and a Falls Reference File has been developed as a reference for staff in the prevention of falls.

Screening and assessing risks of falls and harm from falling

The patient health questionnaire seeks information on falls risk. A falls risk assessment for all patients is undertaken on admission and 2017 auditing of the medical record show 100% compliance. Post fall patients are to have their falls risk re-assessed and 2017 auditing shows 90% compliance.

Education sessions on the Risk Assessment tool has been undertaken. A Falls Reflection Tool has been introduced to assist staff in identifying circumstances that may have contributed to the patient fall. Falls risk assessment forms part of the clinical handover. The outcomes from the risk assessments are linked to the ISBAR patient care plan/handover tool and reviewed with patient input daily.

Preventing falls and harm from falling

In 2017, the hospital introduced April Falls Month to educate staff, family and carers on the strategies available to prevent falls and harm from falls. Falls prevention is part of the hospitals orientation program and ongoing education is delivered to the workforce using a range of platforms which includes shared learning's from other hospitals. The hospital has introduced several preventing falls and harm from falls improvements for example, adding patients falls risk onto the patient care white-board, physiotherapy in-service on preventing falls and the purchase of additional sensor mats.

The patient’s falls risk is considered when nursing management are selecting the patient's room. Purposeful Patient Rounding ensures regular patient observation and access to the nursing staff. To assist patients to receive care as soon as needed, the hospital has had all of its call bell handsets replaced with call bells with a non-slip casing thereby eliminating call bells slipping and not being in the patient’s reach. All patients with a medium or above risk of falling are referred for physiotherapy review. The hospital has an extensive inventory of equipment to assist in preventing falls, for example hi/lo beds, hover mat, non-slip socks and mobility aids.

Communicating with patients and carers

Falls rates are displayed on the MyHealthscope website against the National average. The hospital's patient DVD TV channel plays education on fall prevention strategies. Posters showing Call Before You Fall are used within the clinical area. Patients and carers are involved in post-fall incident reviews where ever possible. The hospital has reviewed its nursing discharge summary form to now include a physiotherapy discharge summary on management strategies used to prevent falls during the episode of care.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

Organisation : Bellbird Private Hospital
Orgcode : 221884

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Bellbird Private Hospital
Orgcode : 221884

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	SM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	SM	SM
1.3.1	Workforce are aware of their delegated safety and quality roles and responsibilities	SM	SM
1.3.2	Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	SM	SM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an	SM	SM

	unexpected deterioration in health status		
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	SM	SM
1.12.1	The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	SM	SM
1.13.1	Analyse feedback from the workforce on their understanding and use of safety and quality systems	SM	SM
1.13.2	Action is taken to increase workforce understanding and use of safety and quality systems	SM	SM

Incident and complaints management

Action	Description	Organisation's self-rating	Surveyor Rating
1.14.1	Processes are in place to support the workforce recognition and reporting of incidents and near misses	SM	SM
1.14.2	Systems are in place to analyse and report on incidents	SM	SM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	SM
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	SM	SM
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM
1.15.3	Feedback is provided to the workforce on the analysis of	SM	SM

	reported complaints		
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

Action	Description	Organisation's self-rating	Surveyor Rating
1.17.1	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	SM	SM
1.17.2	Information on patient rights is provided and explained to patients and carers	SM	SM
1.17.3	Systems are in place to support patients who are at risk of not understanding their healthcare rights	SM	SM
1.18.1	Patients and carers are partners in the planning for their treatment	SM	SM
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SM	SM
1.18.3	Mechanisms are in place to align the information provided to patients with their capacity to understand	SM	SM
1.18.4	Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	SM	SM
1.19.1	Patient clinical records are available at the point of care	SM	SM
1.19.2	Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	SM	SM
1.20.1	Data collected from patient feedback systems are used to measure and improve health services in the organisation	SM	SM

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	SM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM
2.4.1	Consumers and/or carers provide feedback on patient information	SM	SM

	publications prepared by the health service organisation (for distribution to patients)		
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	SM
2.6.1	Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	SM	SM
2.6.2	Consumers and/or carers are involved in training the clinical workforce	SM	SM

Consumer partnership in service measurement and evaluation

Action	Description	Organisation's self-rating	Surveyor Rating
2.7.1	The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	SM	SM
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	SM	SM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	SM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	SM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	SM

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant	SM	SM

Action	Description	Organisation's self-rating	Surveyor Rating
	• reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	SM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	SM
3.5.3	Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	SM	SM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	SM
3.7.1	Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	SM	SM
3.8.1	Compliance with the system for the use and management of invasive devices in monitored	SM	SM
3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM

3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM
3.11.3	Action is taken to improve compliance with standard precautions	SM	SM
3.11.4	Compliance with transmission-based precautions is monitored	SM	SM
3.11.5	Action is taken to improve compliance with transmission-based precautions	SM	SM
3.12.1	A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	SM	SM
3.13.1	Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care	SM	SM
3.13.2	A process for communicating a patient’s infectious status is in place whenever responsibility for care is transferred between service providers or facilities	SM	SM

Antimicrobial stewardship

Action	Description	Organisation's self-rating	Surveyor Rating
3.14.1	An antimicrobial stewardship program is in place	SM	SM
3.14.2	The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage	SM	SM
3.14.3	Monitoring of antimicrobial usage and resistance is undertaken	SM	SM
3.14.4	Action is taken to improve the effectiveness of antimicrobial stewardship	SM	SM

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer’s instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
3.19.1	Information on the organisation’s corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	SM	SM
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	SM	SM

Medication Safety

Governance and systems for medication safety

Action	Description	Organisation's self-rating	Surveyor Rating
4.1.1	Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	SM	SM
4.1.2	Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	SM	SM
4.2.1	The medication management system is regularly assessed	SM	SM
4.2.2	Action is taken to reduce the risks identified in the medication management system	SM	SM
4.3.1	A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	SM	SM
4.3.2	The use of the medication authorisation system is regularly monitored	SM	SM
4.3.3	Action is taken to increase the effectiveness of the medication authority system	SM	SM
4.4.1	Medication incidents are regularly monitored, reported and investigated	SM	SM
4.4.2	Action is taken to reduce the risk of adverse medication incidents	SM	SM
4.5.1	The performance of the medication management system is regularly assessed	SM	SM
4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

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Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

Action	Description	Organisation's self-rating	Surveyor Rating
4.9.1	Information and decision support tools for medicines are available to the clinical workforce at the point of care	SM	SM
4.9.2	The use of information and decision support tools is regularly reviewed	SM	SM
4.9.3	Action is taken to improve the availability and effectiveness of information and decision support tools	SM	SM
4.10.1	Risks associated with secure storage and safe distribution of medicines are regularly reviewed	SM	SM
4.10.2	Action is taken to reduce the risks associated with storage and distribution of medicines	SM	SM
4.10.3	The storage of temperature-sensitive medicines is monitored	SM	SM
4.10.4	A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	SM	SM
4.10.5	The system for disposal of unused, unwanted or expired medications is regularly monitored	SM	SM
4.10.6	Action is taken to increase compliance with the system for storage, distribution and disposal of medications	SM	SM
4.11.1	The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	SM	SM
4.11.2	Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	SM	SM

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM

4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM
4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	SM	SM
5.2.1	The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	SM	SM
5.2.2	Action is taken to reduce mismatching events	SM	SM
5.3.1	Inpatient bands are used that meet the national specifications for patient identification bands	SM	SM

Processes to transfer care

Action	Description	Organisation's self-rating	Surveyor Rating
5.4.1	A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	SM	SM

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure,	SM	SM

	treatment or investigation is regularly monitored		
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.1.1	Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	SM	SM
6.1.2	Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	SM	SM
6.1.3	Tools and guides are periodically reviewed	SM	SM

Clinical handover processes

Action	Description	Organisation's self-rating	Surveyor Rating
6.2.1	The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	SM	SM
6.3.1	Regular evaluation and monitoring processes for clinical handover are in place	SM	SM
6.3.2	Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	SM	SM
6.3.3	Action is taken to increase the effectiveness of clinical handover	SM	SM
6.3.4	The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	SM	SM
6.4.1	Regular reporting, investigating and monitoring of clinical handover incidents is in place	SM	SM
6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	SM	SM

Blood and Blood Products

Governance and systems for blood and blood product prescribing and clinical use

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are	SM	SM

Action	Description	Organisation's self-rating	Surveyor Rating
	consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products		
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	SM
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	SM	SM
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	SM	SM
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	SM	SM
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	SM	SM

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	SM	SM
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	SM	SM
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	SM	SM
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	SM	SM
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	SM	SM
7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

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Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	SM	SM
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	SM	SM
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	SM	SM
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	SM	SM

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	SM	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are	SM	SM

	periodically audited to identify at-risk patients with documented skin assessments		
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.8.1	An evidence-based wound management system is in place within the health service organisation	SM	SM
8.8.2	Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	SM	SM
8.8.3	Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	SM	SM
8.8.4	Action is taken to increase compliance with evidence-based pressure injury management plans	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
8.9.1	Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	SM	SM
8.10.1	Pressure injury management plans are developed in partnership with patients and carers	SM	SM

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system	SM	SM

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Action	Description	Organisation's self-rating	Surveyor Rating
	• communication about clinical deterioration		
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM
9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance are regularly reviewed	SM	SM
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	SM	SM

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Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM
9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

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Screening and assessing risks of falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.5.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls	SM	SM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	SM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.7.1	Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	SM	SM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	SM
10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	SM
10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
10.9.1	Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	SM	SM
10.10.1	Falls prevention plans are developed in partnership with patients and carers	SM	SM

Recommendations from Current Survey

Not applicable.

Recommendations from Previous Survey

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation

Recommendation: NSQHSS Survey 0215.2.2.1

Recommendation:

Identify and implement a mechanism for involving consumers and/or carers in BPH strategic and/or operational planning.

Action:

As part of the Safety and Quality Program at BPH the QM has implemented consumer activities in line with the Healthscope policy 1.05 Consumers, partnering with

As part of this implementation a Bellbird Consumer Engagement Plan (CEP) was developed 2017 in order to ensure that consumers are involved in both the hospitals strategic plan and operational planning.

The CEP has been reviewed and commented on by BPH Consumer Representative. Some of the consumer suggestions has resulted in changes to BPH Strategic plan including the wording.

The Consumer Representative commented that BPH Strategic plan was extremely detailed and informative.

The current Bellbird Consumer consultant that commenced in March 2017, was provided with a detailed position description and this was discussed with the QM on commencement to ensure that they were clear on their role at BPH and their responsibilities in relation to the Quality and safety program.

On commencement an orientation session was scheduled and undertaken by the Consumer consultant with the Quality manager. At this point their position description and confidentiality agreement was explained and signed by Consumer consultant as part of their induction.

During orientation session areas covered:

1. A scheduled meeting with each Head of Department and the Director of Nursing
2. Hand Hygiene competency
3. A guided tour of the hospital with the QM
4. An overview of National Standards including safety and quality requirements for Accreditation
5. Emergency procedures and BPH MET call protocols
6. Suggestions by Quality manager of quality and safety projects and ideas for the Consumer to be involved in.

Consumer Consultant's regular schedule

The Consumer Consultant meets regularly with the Quality manager as a minimum once each time they are on site.

The consumer consultant's hours are approximately 8 hours per month.

The meeting with the QM and CC include their current quality projects, patient and staff survey results and Bellbird's Quality program activities.

Following the consumer consultant's time spent on the ward completing patient surveys, the consumer consultant then reports back to Quality manager. Discussion of any of their feedback, is then escalated/ communicated back to NUM or DON and added to any reports to relevant committees. All patient feedback is disseminated back to staff, positive and negative for action if required.

The Consumer representative participates on the BPH Quality committee which provides an opportunity for them to report on their current quality projects and any additional feedback from patients and other consumers.

In addition to participating in this committee the consumer consultant meets with DON and Quality manager 3-monthly. These meetings are also documented and include areas such as budgets and strategic/operational planning for BPH.

The consumer consultant is invited to discuss the strategic plan on an annual basis via invitation once the year's planning has commenced.

The Bellbird Private Facebook page and Google reviews are monitored by the Business Development manager. This platform allows for ratings and feedback of varying levels. All negative comments are forwarded directly to the DON, who is Bellbird complaints manager. These are dealt with and managed in a timely manner.

Social media hits and ratings are now included as part of the monthly Board report which is also tabled at BPH Quality committee.

Completion Due By: April 2017

Responsibility: Robyn Langmaid

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

A consumer consultant commenced in March 2017 and has been actively engaged in reviewing the current strategic plan and the Consumer Engagement Plan. There has been some very good work undertaken in regard to patient surveys and feedback from the consumer/patient perspective.

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Survey 0215.2.6.2

Recommendation:

Identify and implement mechanisms for involving consumers and/or carers in the training of the BPH clinical workforce.

Action:

The Bellbird consumer consultant runs informal sessions with ward staff. This forum provides feedback to staff regarding role of consumer, examples feedback she receives from patients. Sessions also allow staff to familiarise themselves with the role and function of the consumer consultant at Bellbird. Feedback following the sessions demonstrate staff have a greater understanding of the role, and the consumer consultant is more familiar with the staff. On evaluation of a session run by the consumer, 96% staff indicated an improvement in the understanding of the role of the consumer at BPH.

Bellbird consumer consultant provide feedback of results of patient satisfaction survey results, patient questionnaires that they have undertaken at the Quality meeting. This formulates part of the report tabled by the consumer at the Quality meeting.

Consumer consultant provide feedback to staff on ward from patient questionnaires.

Consumer biography included in New Employee Orientation manual.

Healthscope Clinical Handover DVD was developed with a consumer group at the corporate level with another of the Healthscope hospitals for all hospitals to utilise for staff education. For the production on the DVD a number of key stakeholders including consumers contributed in the planning stage, reviewing the proposed scenarios, who would be involved, terminology used and the ability to make them as realistic as possible. This DVD is being shown to staff at Bellbird as an education tool around clinical handover. Staff were asked to complete an evaluation following watching the DVD and answer the following

How informative/useful was this education sessions for you? - 92% of the staff responded that they found it informative/useful

They were asked to rate their knowledge before and then after watching the DVD, we found that 78% of the staff that responded stated that their knowledge had increased after watching the DVD.

Completion Due By: 01/06/2015

Responsibility: Robyn Langmaid

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Since the engagement of the consumer consultant there have been regular sessions conducted for the staff to help them understand more about the importance of their role in the delivery of care and services. Results from patient surveys also contribute to the education sessions which has helped. Staff evaluation of the sessions is rated extremely high.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Recommendation: NSQHSS Survey 0215.9.9.3

Recommendation:

Periodically review the performance and effectiveness of the system for family escalation of care.

Action:

The performance and effectiveness of system of MOCK CODE scenarios has been added to the BPH audit schedule. This ensures a systematic approach to the review of the systems in place.

Reflection and outcomes discussed as part of debrief following Mock code. The MOCK code allows for all staff involved to practice the response and increases awareness of methodology of family/patient or carers escalating care.

As a result of a mock code the following action was taken:

Issue- ASSIST call bell not always accessible (located on wall behind patient bed)

Action- An additional step added to process, to call 321 on bedside phone. Patientcare board template was updated to reflect the new step in the process.

Outcome- mock code performed- escalation by calling 321- NUM then escalated to call over PA system. 100% compliance with use of new step.

Completion Due By: 01/06/2015

Responsibility: Robyn Langmaid

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

In the absence of any recorded family escalation of care calls the organisation undertook a mock escalation of care call using the relative of a patient. Reflection and debrief from the mock escalation resulted in the implementation of a change to practice. The mock code escalation has been added to the annual audit schedule.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.4 Action is taken to improve the system performance for family escalation of care

Recommendation: NSQHSS Survey 0215.9.9.4

Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Action:

Consumer Representative discusses patient care boards with patient during patient interviews. The representative also discusses this with the family or any carers if available at time of visit.

Consumer Representative and other consumers reviewed patient education TV channel.
92% found the channel informative
86% found it easy to understand
94% good quality picture
78% knowledge increased after watching DVD
Some consumers commented that there was a lot to absorb in the DVD, and suggested that a voice talking rather than the words on the screen would be easier to comprehend.

It is acknowledged that the system for escalation of care by family/carer be included in more detail in version 2.0.

It is likely that the DVD will be updated to keep in line with Version 2.0 National Standards

Completion Due By: 1/8/2017

Responsibility: Robyn Langmaid

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Evidence has been provided that improvements in the system for family escalation have been identified and implemented. Ongoing monitoring is in place.

Organisation : Bellbird Private Hospital
Orgcode : 221884

Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

NSQHSS Survey

Organisation : Bellbird Private Hospital
Orgcode : 221884

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**