Report of the ACHS EQuIPNational Organisation-Wide Survey

Brisbane Private Hospital

Brisbane, QLD

Organisation Code: 72 05 61

Survey Date: 11-14 September 2017

ACHS Accreditation Status: **Accredited**

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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 OWS 0613. 1.1.1 is a recommendation from an OWS 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.

EN OWS

Organisation: Brisbane Private Hospital
Orgcode: 720561

Survey Overview

Brisbane Private Hospital (BPH) is a 145-bed facility located in the heart of the Brisbane CBD and provides surgical, rehabilitation and drug and alcohol services.

BPH is owned and operated by Healthscope Ltd (HSP). The HSP National team provides support to the workforce through policies, guidelines and frameworks and opportunities to participate in benchmarking with facilities in the HSP Group.

This EQuIPNational (EN) Organisation-Wide Survey was undertaken on the 11th – 14th September 2017 and included an on-site visit by three surveyors.

It is evident that the Executive and staff are continuing to strive for excellence in the standard of healthcare provided. A distinct focus is evident throughout the organisation on the engagement of the hospital's workforce to ensure safe and quality care is provided for consumers and in fostering partnerships with consumers and carers. The survey team was impressed with the progress made by the organisation in the implementation of the EN standards and development of services since the EN Periodic Review in October 2015.

The facility has been undergoing extensive capital redevelopment to upgrade facilities and includes a ward refurbishment project and substantial increased provision of private rooms. A major development project of a 4-floor new hospital wing at the front of the hospital is currently in progress and incorporates 26 acute surgical beds, and for the next phase of improvement four additional operating theatres is planned, two of which are proposed to be commissioned immediately on completion of construction. The Damascus Drug & Alcohol inpatient unit and Day Programs are scheduled to relocate to the new building and expand to 41 inpatient beds in October 2017. Patient flows and management processes are being reviewed and redesigned in consultation with consumers.

BPH has achieved the following Met with Merit ratings:

3.5.1 - Workforce compliance with current national hand hygiene guidelines is regularly audited;

3.5.2 - Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation; and

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.

All other Core and all the Developmental actions are assessed as Satisfactorily Met (SM). Core transitional actions 3.10.1 and 9.6.1 are assessed as fully met.

The Executive and staff are congratulated on their enthusiasm demonstrated during the survey and their achievements in the hospital's safety and quality program.

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STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Brisbane Private Hospital (BPH) has a well-developed integrated system of governance that manages patient safety and quality and is supported with a clearly documented committee structure. The peak quality and safety committees are the Quality Committee and the Patient Care Review Committee which report to the Executive Committee. Evidence was available indicating that the committees met regularly and have standing quality and safety agenda items, and the Medical Advisory Committee (MAC) and the Healthscope (HSP) National Safety and Quality Committees regularly receive reports on safety and quality performance.

The system for management of policies/procedures and clinical guidelines is well-established at both corporate and local levels, with evidence of version control, ongoing review and currency of information. HSP policies/procedures/clinical guidelines are integrated into an electronic directory which is available on the HSP Intranet (HINT). BPH policies/procedures are available on the BPH Intranet. Hard copy policy/procedure manuals are maintained in the Executive Suite. Processes for communicating new and revised policy documents to the workforce are well-established. Compliance with policies occurs via audits and incident monitoring. Processes are well-established for ensuring legislative compliance and alerts when legislative changes occur and for communicating new and revised policy documents to the workforce. It is suggested that ease of access of policies/and procedures by end-users be formally evaluated.

Consideration of patient safety and quality of care is evident in the BPH Strategic, and Safety and Quality plans. Performance on safety and quality indicator data is monitored by the Quality Committee, the Executive Committee and the HSP National Safety and Quality Committee. Performance is monitored against targets and reports are regularly submitted quarterly to HSP Corporate where performance is benchmarked with other HSP hospitals.

A comprehensive range of quality and safety audits is conducted and supported with an audit schedule which has been subject to review and refinement. The introduction in 2016 of automated handheld devices with TopCat software for auditing throughout the hospital was reported to have been associated with improved ease of auditing, improved quality of audits and increased compliance in timeliness of completion of audits as per the revised schedule requirements; however, there is difficulty in preparing reports by end uses. The organisation is encouraged to refine the TopCat reporting system in collaboration with the software developer to facilitate ease of preparation of reports by end users. In addition, the organisation is encouraged to strengthen trending and reporting on comparison of performance over time.

Position descriptions indicate workforce responsibilities for safety and quality. Reporting lines and responsibilities of staff are clearly outlined in the BPH organisation chart. Orientation, mandatory and in-service education programs provide information related to safety and quality responsibilities of the workforce and are provided via face to face education sessions and eLearning. Processes for orientation staff are well developed and supported with a comprehensive education program and educational resources. The organisation reported that there is low usage of agency staff. Records show very high levels of staff compliance with the mandatory training programs and competency assessments that are conducted to address the requirements of the NSQHSS. The organisation is congratulated on these achievements.

The risk management system is overseen by the Executive & the Quality Manager and is well-developed, and supported with policies which provide the framework for risk management across the organisation, the use of RiskMan and staff education in risk management. The risk register incorporates clinical and corporate risks and reflects issues arising from incidents, inspections and reviews. There is evidence of risk rating, use of controls and risk mitigation activities, ongoing review of relevant aspects of the risk register by relevant committees, and monitoring of outcomes. Time-based alerts are used to ensure compliance with all risk register review dates which is closely monitored by the National Risk Management team.

The quality system is very well-established and demonstrates good linkage with the risk management system. Quality activities are documented in the BPH Quality and Safety Clinical Governance Framework which is linked to the National Clinical Governance Framework. A wide range of quality improvements were demonstrated throughout the hospital. Notable examples include: patient Identification, clinical handover, clinical deterioration and care coordination, identification and tracking of infection status of patients.

Clinical practice

A range of clinical guidelines and clinical pathways are in use show evidence of review. A generic care plan is in use in the Damascus Unit for the care of drug and alcohol patients. The models of care for rehabilitation patients and drug and alcohol patients are multidisciplinary and very well- developed and include goal setting and case reviews of all patients. Management of patient flows and discharge planning are supported with care coordinators.

Processes are established for variance analysis of clinical pathways, ongoing review of care plans, monitoring of length of stay of all patients and variances against expected ALOS. Mortality and morbidity data and ACHS indicator data is subject to regular review by clinicians, the Quality Committee and Patient Care Review Committee and the Executive.

A suite of HSP policies provides the framework by which the organisation identifies patients at increased risk of harm and includes an extensive suite of screening and assessment policies/procedures and tools developed by HSP Clinical Clusters and which are standardised across HSP hospitals. There is a HSP exclusion policy provides the framework and criteria for patients who should not be admitted to BPH and mechanisms are well-established to monitor compliance to ensure admissions are in accordance with approved clinical services capability. During survey, a policy/procedure was documented to support the application of criteria for admission exclusions of paediatric patients is as per the BPH QLD Health license and to support the HSP policy.

Use of risk assessment tools is incorporated in the pre-admission assessments and completed in pre-admission and admission and ongoing patient management processes. Risk assessments include falls, malnutrition, pressure injury, and infection and cognitive status, allergies, VTE, medication risk and discharge risk. Alerts are documented in the patient clinical record, the electronic administration information system and in other communication tools. At-risk patients are discussed at handover meetings. Management plans are developed for patients identified at risk. An electronic leave register is used in the Damascus Unit to manage leaves of drug and alcohol patients and assists in the follow-up of patients. Audit results show good compliance with completion of risk assessments and implementation of appropriate management plans.

An effective system for escalating care is established and is discussed more fully in Standard 9.

It is noted on survey that BPH fulfils all the necessary requirements under this criterion regarding clinical records. Patient notes are freely available at point of care. All charts are able to be obtained relatively easily from either the secure storage area on site or from the off-site area.

Performance and skills management

HSP By-Laws provide the framework for credentialling and approval of scope of practice of medical officers which is overseen by the Medical Advisory Committee. Applicants are required to provide evidence of credentials, referees, verification of insurance and details of scope of practice sought and a copy of a CV. eCredentialling was introduced April 2016; an electronic database is used to maintain medical and dental officer's records and scope of practice. The scope of practice of dental assistants has been recently developed by BPH craft group and checked by HSP Chief Medical Officer. The survey team was advised that consideration is being given to rolling out this to other HSP hospitals.

With regards to re-accreditation the Medical Advisory Committee considers patient outcomes, adverse events, complaints, participation quality assurance activities and continuing professional development. HSP Corporate Office conducts quarterly audits on the credentialling system and evidence provided showed very high compliance with requirements.

Medical, nursing and allied health registrations are subject to online currency checks via AHPRA. Appropriate processes for defining and monitoring the scope of practice of nursing and allied health workforce are in use and include the use of position descriptions. Mechanisms for clinical supervision of RMO, and nurses and allied health workforce and students are well developed.

Appropriate processes are established for the safe introduction of new interventional procedures.

Performance appraisal systems for nursing, allied health and support staff are very well developed with 93% compliance with annual performance appraisals reported.

Feedback from the workforce on their understanding and use of safety and quality systems occurs via their evaluation of education sessions and workforce surveys. Education is tailored to meet training needs identified in performance and development reviews, audit results, and incident trends, workforce surveys and is oversee by a BPH Education Committee with site educators and Executive membership. BPH Educators participate in the HSP Educator Clusters. Evidence provided showed clinical and non-clinical managers have participated in Proteus leadership programs and a range of opportunities are available for the workforce to participate in external professional development programs, including the HSP leadership and quality programs. The survey team observed that the clinical and non-clinical workforce demonstrated good understanding and application of safety and quality.

Incident and complaints management

The systems for management of incidents and complaints are well-developed, and supported by HSP policies, use of RiskMan and staff education. The RiskMan system includes extensions requiring controls to be completed for NSQHSS, maintenance of registers of incidents /near misses and complaints, categorisation and risk rating of incidents and complaints according to severity. Management of incidents and complaints is overseen by the General Manager, Director of Nursing and the Quality Manager.

The RiskMan reporting system includes automatic notification of all incidents and feedback to the Healthscope and local Executives. Mechanisms are established for notification of the Executive, the HSP National Risk Manager when a sentinel event occurs. Critical System Reviews are conducted on Sentinel and Medibank identified complication (MIC) events to analyse contributing factors. The HSP National Risk Manager provides support as required. There is evidence of good compliance by the hospitals with the submission of reports related to investigations/follow-up action for sentinel events to the Corporate level within the HSP target timeframes. Incidents are communicated to the workforce once confirmation and initial investigation has occurred. Healthscope sentinel events reports summaries (Shared Learning Reports) are disseminated to the workforce by the Executive.

Monitoring of performance is overseen by the Quality, Patient Care Reviews and Executive Team Committees. Medication incidents, related to omissions and prescribing are noted to be the highest occurring incidents. The organisation is encouraged to use trended data performance regarding the frequency of incidents to assist in monitoring of performance.

Quarterly Quality and Safety Reports submitted to HSP show very high compliance by BPH in meeting HSP target timeframes KPIs for complaints acknowledgement and response.

Application of the National Open Disclosure Standard is undertaken in association with investigation of incidents/complaints. Open Disclosure events are entered into RiskMan and clinical records. Evidence showed 97% of the BPH clinical staff have completed open disclosure training.

Patient rights and engagement

BPH has a Patient Charter of Rights and Responsibilities consistent with National standard. Information regarding this Charter is provided to patients on admission, patient information directories and is present in patient care areas and the BPH website. Translation of information is available via interpreter services.

Results of the Patient Satisfaction survey 2017 showed patients indicated very high levels of understanding of their rights and responsibilities and high levels of involvement in making decisions about their care. Bedside Patient care boards are in use in all clinical areas to facilitate communication and partnering with patients and carers. Clinical Pathways have provision for nurse to document patient involvement in care planning. In the Damascus Unit care plans have provision for signature of drug and alcohol patients to indicate involvement in care planning. Clinical Record Audit 2016 results show 82% compliance.

Systems for management of consent are well-established and are subject to ongoing monitoring and audit. Clinical Record audits results show very high compliance. A separate consent form is used for blood transfusion procedures. Consent for photographs of pressure injuries and wounds is obtained and documented in the clinical progress records. This is further supported with a Healthscope Corporate policy.

Information is provided to patients regarding completion of advanced care directives and includes a comprehensive HSP brochure. Mechanisms are established for incorporation of alerts when patients present with an Advance Care Directive and when treatment limiting orders are established during a patient's episode of care. Advanced Care Directives are not completed on site by the BPH workforce.

Clinical Records are freely available at point of care. BPH uses a paper based record which is kept on site for at least two years but is available with as little as a one hour turnaround time from Iron Mountain records. It is noted that both pathology results and radiological results are available as well at the point of care. As mentioned elsewhere in this report, archival storage is secure and easily accessible. The pre-admission paper work has a full consent process in place including informed consent. In order to access the electronic pre-admission, a log in password with SMS authorisation is mandatory.

Data collected from patient satisfaction surveys, complaints and compliments and Damascus Unit consumer focus groups are used to gain feedback on patient experiences at BPH and actions plans developed and improvements implemented as required. Patient Experience Trackers (PETs) incorporating the HSP Patient Satisfaction survey questions are in use and reports results are graphed and trended subject to ongoing monitoring by the Quality Committee. Results show average satisfaction levels are greater than 90%. Examples of improvements made as result of feedback from patients include adjustments to menus, and implementation of strategies to reduce noise in clinical areas, improved orientation of patients on admission to ward areas and introduction of way finding kiosks, changes to day programs in the Damascus Unit.

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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

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STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The governance arrangements for consumer partnership occur within the framework of the HSP Partnering with Consumers Policy and the BPH Quality and Safety Plan, and are supported by consumer consultants. There are consumer representatives for the organisation, including the general hospital and the Drugs & Alcohol (Damascus) Unit. The General Consumer Consultant is a member of the Quality Committee and provides reports on consumer consultant activities. The Damascus representatives (3) are all past patient/clients and participate in a range of planning, review and operational meetings.

There are clearly documented consumer consultants position description and arrangements are established for their participation in orientation programs, and strategic planning activities. Damascus Consumer Consultants have a separate documented position description and their participation includes attendance at the unit's quarterly planning meetings and annual consumer focus groups. Damascus consumer consultants chair the secondly weekly patient's community forum and one attends the Relapse Prevention Program Recovery to support new patients.

Mechanisms are well-developed for communicating the activities of the consumer representatives to the workforce, patients and carers and include regular meetings with the Executive and the Quality Manager, participation in staff meetings and display of information within the Damascus Unit.

Evidence was available demonstrating that Consumer Consultants have been consulted in the development and revision of publications/patient information materials and that feedback has been incorporated in the documentation. A HSP logo, is used to indicate a Consumer Approved Publication and applied when an organisation demonstrates that required criteria are met. Examples include development of the REACH brochure provided to patients regarding escalation of care and review of Damascus Unit brochures.

Consumer partnership in designing care

Mechanisms for the participation of consumers in designing and redesigning care are established and have included consultation and participation in planning for the major development project which h is currently in progress. Consumer Consultants attend the Project Access Planning Committee. Damascus consumers have been involved in the review and redesign of patient admission processes.

Patient-centred care education is incorporated in orientation, mandatory eLearning and in-service education programs provided for the workforce. Records show participation in the eLearning program at the time of survey was 92%.

Consumer consultants provide education to the workforce through contributions to the orientation program and meetings with the workforce. The General Consumer Consultant is involved in the orientation program in relation to the topic of Customer Service. The organisation is encouraged to consider the use of DVDs which include the use of patient stories.

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Consumer partnership in service measurement and evaluation

Mechanisms are established for providing the community and consumers with information on the safety and quality performance of the organisation and include availability of information on the My Healthscope website and in newsletters. Information on performance on the safety and quality indicators is not currently displayed in public areas of the hospital. This aspect should be addressed and include trended performance such as hand hygiene compliance and falls incidents.

There is evidence of consumer consultant participation in measurement and evaluation of services and safety and quality performance and in quality activities. Examples of consumer participation in quality activities include evaluation of bedside clinical handover activities and adequacy of information provided to patients regarding the escalation of care program (REACH).

A Damascus Consumer Consultant has represented BPH and participated the Queensland Network of Alcohol Drug Agencies (QNADA) in the identification and improvement of outcome measures and which has resulted in the planned introduction of The Australian Treatment Outcomes Profile “ATOP” at BPH. Feedback from Damascus Unit consumer consultants and patients has been used to review Day Programs.

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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

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STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

BPH has engaged the services of HICMR (Healthcare Infection Control Management Resources) to work collaboratively with the organisation in the development of their Infection Prevention Control (IPC) Risk Management Plan 2017 -2018. The Plan articulates the practical facility-wide IPC risk minimisation strategies that are evidence-based and in line with relevant legislative requirements for effective Infection Prevention and Control (IPC) outcomes. The IPC Plan is aligned with and adapted from the NSQHS Standard 3: Preventing and Controlling Health Care Associated Infections. The program is reviewed and updated annually by external infection and control consultants from HICMR. Last review was undertaken August 2017 and indicated a score of 99% compliance with the assessment across the eight criteria assessed.

The plan is supported by a range of evidence based and regularly reviewed HICMR Infection Prevention and Control (IPC) Policies which are available at the point of care to support staff and guide practice on the BPH Intranet. Policies align with the National Health and Medical Research Council (NHMRC) standards for clinical practice guidelines where relevant, and ISO 90001: Quality management systems - Requirements. Policy and guidelines are regularly reviewed as part of the HICMR contract.

The plan has been endorsed by the Director of Nursing; the Executive Team supports the Infection Prevention and Control Program. . An IPC Consultant provides support to the program.

An Infection Prevention and Control Committee is in place to provide oversight of and monitoring of the outcomes of the Infection Prevention Control (IPC) Risk Management Plan 2017-2018. Terms of reference are in place for the committee, with these having been evaluated in 2016 with results in all areas indicating exceptionally high performance (100%).

Currently there is no consumer representative on the Infection Prevention and Control Committee, the organisation is encouraged to investigate opportunities around this. Reporting is in place from the Infection Prevention and Control Committee to the Quality Management Committee and Medical Advisory Committee. Minutes of these committees were reviewed that verified reporting of performance, issues and actions.

The IPC program is well championed and supported by the executive leadership team and well trained and enthusiastic infection control staff (link nurses).

There is regular monitoring undertaken of key performance indicators to the highest level of governance within the organisation (Quality Management Committee and Medical Advisory Committee) that includes quarterly reporting against HSP Corporate Quality KPIs , monthly surveillance reports to the Infection Control Committee and Clinical Graft Groups Review Committees and regular reports on performance against the Infection Control Management Plan reported by the Infection Control Coordinator to the Quality Management Committee.

A very comprehensive surveillance program is in place across the BPH appropriate to their client group. This is supported by the RL6 database which went live in 2015 and enables live feeds from pathology companies and interfaces with the patient management data base (WebPAS). Results are reported quarterly to the Infection Control Committee. Processes are in place for the reporting and notification of results.

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The April 2017 reporting period indicated a reporting rate outside the acceptable range for surgical site infections (hips/knees).

The survey team was able to verify that appropriate reviews and investigations were undertaken across the entire system and corrective actions had been implemented. For the reporting periods following (May-July) 2017 there had been nil SSI infections reported. Results for the April-June 2017 indicate a HAI rate of 0.24% (1/4159) patients' target 2.0 (below benchmark).

The survey team was able to verify good evidence of a robust and comprehensive infection prevention and control program firmly embedded in the safety and quality culture across BPH.

Infection prevention and control strategies

Hand hygiene compliance against the 5 moments across all clinical disciplines at time of survey was 90.1% for the second quarter (April-June) 2017.

Nursing	Allied Health	Medical
92.3%	77.4%	87.4%

Strategies are in place should compliance within clinical units fall below 80% through the implementation of increased Infection Control rounding, on line learning and targeted education. The Hand Hygiene program is taught at the time of orientation and annually through the self-directed infection control eLearning modules through HHA which all staff are required to complete with current compliance of completion at time of survey indicating 96%. Staff are also required to complete the Infection Control Module which includes PPE, sharps handling and direct patient care – this includes some aspects of hand hygiene, current compliance of completion at time of survey indicating 94%. Performance data for hand hygiene rates is routinely reported as part of the Healthscope Quarterly Quality KPI to Executive.

The My Healthscope site provides hand hygiene compliance data for public display, with data available from 2013 indicating a compliance of greater than 85%. There is an extensive list of actions that have been undertaken and implemented to minimise and prevent infection risks to patients as a result of poor hand hygiene techniques and compliance. These include a structured education and training program with hand hygiene included within orientation, in service and mandatory training programs resulting in workforce training of 96%, gold standard hand hygiene auditors and trained auditors, placement of hand sanitiser dispensers in convenient areas throughout the hospital and monitoring of these for both usage and skin irritation.

Collectively, these actions result in performance measures that enabled the organisation to demonstrate improved and consistent compliance across all disciplines (nursing, allied, medical and hotel services) and across all the five moments of the hand hygiene audits over the last three years. Results of the organisation's performance is above average when compared to their peer's comparative data. This has been sustainable over time. The actions related to Hand hygiene 3.5.1 – 3.5.2 were rated Met with Merit (MM).

Healthcare workers are provided with a comprehensive risk- based immunisation program with additional services provided to facilitate compliance with relevant jurisdictional occupational health and safety requirements. Results indicated an uptake of 60% of staff with the 2016 annual vaccination program, this was comparable to the previous year. There has been a concerted effort to improve documentation of staff vaccination status with evidence of marked improved in recoding of status of Category A from 2015 to 2017 YTD. A staff health module has been developed within the RL6 database which interfaces with payroll and enables the recording of vaccination status, body fluid exposures, allergies (latex).

Policies relating to invasive devices are available to support staff and state the requirements for training and competence in the use of specific devices.

Training programs are in place for: Peripheral intravenous venous cannulation, indwelling urinary catheter or wound dressing.

Audits are undertaken to assess compliance with the management of invasive devices with an audit undertaken between 27 February and 3 March 2017 of all in patients excluding Day only patients) with and indwelling device: peripheral Intravenous Cannula, indwelling urinary catheter, arterial line, pain pumps or wound drains. Results indicated that there was room for improvement in documentation of invasive devices and the monitoring of these, this includes date of removal. An action plan was in place to address these findings.

An Aseptic Technique Procedure is in place to provide support and guidance to staff. All staff are required to complete an online theoretical training program – Australian College for Infection Prevention and Control through ELMO (read workbook and answer questions) followed by assessment of clinical competency annually - thorough a specific clinical procedure aligned to their scope of practice i.e. Peripheral intravenous venous cannulation, indwelling urinary catheter or wound dressing.

	Nursing	Medical	Allied Health
Theory /Education -	94%	100%	N/A
Practical (competency)	92%	100%	N/A

NB. No allied health staff undertake procedures that require aseptic technique training and competency assessments.

A key group of staff have been trained to assess ANNT competencies with a train the train program having been implemented to support the process. Processes are in place for the feedback of results to the clinical areas with strategies identified to address areas of non-compliance.

The transitional arrangement for aseptic techniques has been met to the full intent until 2020 with evidence of 94% of the required clinical workforce being trained in aseptic technique.

Managing patients with infections or colonisations

The organisation has sufficient capacity to manage the complex needs of patients requiring additional infection control precautions. There are large proportion of private rooms with their own ensuites.

Healthcare workers are supplied with equipment and an environment to enable compliance with standard and transmission- based precautions. Environmental and standard precautions audits are undertaken as part of the organisation's audit program, outcomes from these are positive (>98.9% compliance). The use of observational audits to assess correct usage of PPE by the infection Control Consultant and IC Link Nurses are encouraged as the times for use and requirements is infrequent.

Electronic infection control alerts are in use through WebPAS, patients with an infection control history are incorporated into the admission system to facilitate the appropriate placement of patients requiring transmission-based precautions and on the front of the RL6 database. At the time of survey, the organisation was in the process of implementing the 'Responder 5 Nurse Call' system which has the ability to use corridor lights to flag at risk patients. This will enable those patients with a known infection control risk to be identified prior to entering their room.

Audits of the discharge/transfer/referral documentation demonstrate that patient's infectious status and/or clearance is communicated whenever responsibility for care is transferred within or between departments or facilities.

Antimicrobial stewardship

BPH has good structures in place for the various areas required under this criterion. They have an anti-microbial stewardship committee in place which is a subgroup of the infection control committee. The members of this group comprise an infectious disease medical practitioner, a microbiologist, a pharmacy representative and nursing including the infection control nurse. The Intranet has up to date prescribing guidelines and these are freely available. The use of the “traffic light system of coding for antibiotics” is noted. Any use of so called red coded antibiotics is monitored through the pharmacy and feedback is provided to the prescribing physician as to the appropriate use of such antibiotics.

Cleaning, disinfection and sterilisation

Maintenance and cleaning schedules are in place and environmental auditing is undertaken with results indicating a high level of compliance. Results from the August 2017 HICMR audit indicated 98% compliance and increase of 3% from the August 2016 audit. This is verified through the results of the most recent HSP *Your Experience Survey,* July 2017 that indicated that consumers are pleased with the cleanliness and presentation of the environment of the organisation and facilities. 76% of patients indicated that their rooms and bathrooms were kept clean, 93% indicated that housekeeping staff were helpful and 84% indicated their room was of the right temperature.

All clinical areas were observed to be clean and well maintained.

Separation of clean and dirty linen is appropriate. The laundry is 99% compliant with AS 4146 – 2000 Laundry Practice.

An appropriate waste management system is in place supported by a Waste Management Plan approved by the Waste Management Sub-Committee, WH&S Committee and Infection Prevention and Control Committee. Active waste reduction, segregation and recycling programs are in place e.g. liquid drug waste buckets to ensure correct disposal of liquid drug waste. Independent annual waste audits are undertaken by the organisation’s contracted waste company demonstrating effective waste management in regard to correct disposal of clinical waste, segregation and recycling. Results are made available to the Waste Management Committee and the Infection Prevention Control Committee.

Instruments are either single use only or where they require reprocessing rigorous policies and procedures have been established and are in place to assure the quality and safety of reprocessed reusable medical devices. The organisation makes use of a large number of loan equipment. A tracking system is in place that allows for the identification of patients and the reusable devices, equipment and instruments.

A gap analysis has been undertaken against AS/NZS 4187: 2014 demonstrating a high degree of compliance (91%). Areas of non-compliance (9%) have been risk-assessed. An action plan has been developed to address these findings, with this incorporated as part of the Quality Improvement Plan for Preventing and Controlling HealthCare Associated Infection. Monitoring of this is through the Infection prevention and Control Committee, of which the Infection Control Coordinator is the Chairperson. The Director of Nursing is the Executive attendee for the Committee. The areas of non-compliance (high risk) are also noted in the BPH risk register.

Reprocessing of reusable medical equipment, instruments and devices meets AS4187. Reprocessing of endoscopes meets national standards and manufacturer instructions.

Staff are trained in the requirements of a sterilising department and there is ongoing competency assessment and education.

EN OWS

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Communicating with patients and carers

Consumer- specific information on the management and reduction of healthcare associated infections is provided to patients and carers. It is suggested that the organisation develops and implements specific processes to evaluate the effectiveness of this information. Results from the most recent patient satisfaction survey indicate that patients received and understood information being provided to them, this however was generic information and wasn't specific to infection prevention and control.

The MyHospital website displays a large amount of data relating to infection prevention and control including hand hygiene and healthcare associated infections. This data is presented over time allowing comparisons to be made and also includes information about the organisation is doing to prevent infections.

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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	MM
3.5.2	SM	MM
3.5.3	SM	MM
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 3.5.1 Core

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

Surveyor Comment:

The organisation has been able to demonstrate improving and consistent compliance across all disciplines (nursing, allied, medical and hotel services) and all the five moments of the hand hygiene audits over the last three years. Results of the organisation's performance is above average when compared to their peer's comparative data. This has been sustainable over time. The action is rated Met with Merit (MM).

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Surveyor's Recommendation:

No recommendation

Action 3.5.2 Core

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

Surveyor Comment:

The organisation has been able to demonstrate improving and consistent compliance results across all disciplines (nursing, allied, medical and hotel services) and all the five moments of the hand hygiene audits over the last three years. Results of the organisation's performance is above average when compared to their peer's comparative data. Performance data for hand hygiene rates is routinely reported as part of the Healthscope Quarterly Quality KPI to Executive. The My Healthscope site provides hand hygiene compliance data for public display, with data available from 2013 indicating a compliance of greater than 85%. The action is rated Met with Merit (MM).

Surveyor's Recommendation:

No recommendation

Action 3.5.3 Core

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

Surveyor Comment:

There is an extensive list of actions that have been undertaken and implemented to minimise and prevent infection risks to patients as a result of poor hand hygiene techniques and compliance. These include a structured education and training program with hand hygiene included as part of orientation, regular in-service and mandatory training programs resulting in workforce training of 96%, gold standard hand hygiene auditors and trained auditors, placement of hand sanitiser dispensers in convenient areas throughout the hospital and monitoring of these for both usage and skin irritation.

Collectively, these actions result in performance measures that have been able to demonstrate sustainable performance above average when compared to their peer's comparative data.

The action is rated Met with Merit (MM).

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

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

Surveyor Comment:

Brisbane Private Hospital has met the full intent of the requirements prescribed under the flexible arrangements for aseptic technique in place with annual mandatory training records indicating 96% compliance for all staff.

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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

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Action 3.16.1 Core

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

Surveyor Comment:

A gap analysis has been undertaken against ASNZS 4187:2014 demonstrating 91% against the required actions. Areas of non-compliance (9%) have been risk rated with an Action Plan developed and in place to address these findings.

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: Brisbane Private Hospital
Orgcode: 720561

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

BPH has a range of governance policies and initiatives to address the safety of their medication system. There is a Medication Safety Committee that oversees the safe use of medication. The organisation has participated in the National Inpatient Medication Chart audit as well as the Medication Safety Self-Assessment (MSSA). As a result of the latest MSSA audit, a comprehensive action plan has been developed to address some perceived short comings revealed in the audit. An example is to increase the patient information area. There has been a steady improvement, however, in all aspects monitored by this audit. BPH fulfils the legislative requirements regarding restricted medications as well as the disposal of such medication.

It is noted that the use of the dangerous drugs under the acronym PINCH is well done but it is suggested that standardisation of the labelling of these containers be considered. It is noted that various clinical areas have different coloured labelling. Tallman lettering is also noted and audits of staff reveal good understanding of the use and efficacy of this. The hospital will be changing to the new PBS Inpatient Chart for Medication in October. The organisation is encouraged to monitor and assess this new process with regular auditing of the understanding of the use of this Chart.

Documentation of patient information

There is an onsite Pharmacy group EPIC with a resident pharmacist on duty as well as on call 24hrs per day. The use of red alert patient identification bracelets is noted as well as allergic reaction warnings in the patient file. An advantage of the onsite pharmacist is in the review and monitoring of at risk patients. It is policy that all patients over 65 in age with co-morbidity and on multiple medications are reviewed. This review is highlighted in the patient note in purple handwriting. Inspection of a range of clinical files showed good incidence of a full medication history as well as medication reconciliation both during the episode of care and on discharge. Any adverse incidents are reviewed by the medication safety committee. There is evidence viewed of training for the NIMC. Consideration will need to include training for the introduction of the PBS Inpatient Chart beginning in October.

One area noted was the audit of medication being documented and reconciled at admission and transfer of care. This showed just on 80% compliance but the target is 90% so work needs to continue in this area to achieve the higher figures.

Medication management processes

Information on the use of medications and indications and side effects is freely available in each clinical area with the use of dedicated iPads as well as hard copies of the MIMS publication. Review of the pharmacy safety subcommittee minutes confirmed the continual upgrading of information. A particular feature of the impress areas in each clinical site is the locked nature of these areas with swipe card access only allowed and this access is centrally monitored. Within these areas the dangerous drugs cupboards were locked with up to date registers of use. Under Queensland Health regulations it is not mandatory to have single use sign out of these medications in the operating theatre but BPH is rolling out the use of locked cupboards within each theatre and will encourage single use sign out rather than the process now where these medications are taken in bulk at the beginning of the operating list. There are locked drug cupboards within each patient room for the medications being used in the clinical episode and these are strictly kept just for medication. It is noted that in the drug and alcohol unit, DAMASCUS, no drugs are kept in individual locked cupboards within the patient's room.

An initiative noted is the double checking taking place in the paediatric ward for medication. Another advantage of the use of Clinical Care Coordinators is their input with the reconciliation of medication through their involvement in the electronic pre-admission.

Inspection of minutes of the Medical Advisory Committee has highlighted the non-approved use of text messaging orders and action needs to address this issue.

Continuity of medication management

The use of the Inpatient review of medication is noted. As stated previously all at risk patients are reviewed and documented action plan is filed in the notes under a purple coloured hand written note by the pharmacist. The use of the iPad in the ward with up to date drug information is noted. A Top Cat audit of medication recently showed 92.2% of charts audited had a documented action plan. A number of audits of patient feedback are available. They show overall good understanding from patients of their medications and usage and reasons for usage. This should continu**e.**

Communicating with patients and carers

BPH has a full time pharmacist available during regular day time hours with on call at other times. This allows extremely good contact with both patients and their relatives/carers. Audits are available that showed an agreed documentation plan in over 92% of charts audited in the MSSA audit recently completed. A further reported audit showed patient satisfaction of over 60% in their appreciation of medication as well as the explanation of potential side effects. BPH is encouraged to continue the feedback from their consumers and to endeavour to improve this figure of just on 60% alluded to above.

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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

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STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

BPH has organisation-wide local procedure in place to support the correct identification of patients at any point in time during an admission or course of treatment including bedside clinical handover, medication administration and escalation of care supported by the HSP Admission of a patient Ref 2.65 and Patient identification bands Ref 2.08 Policy and procedure documents. These documents are accessible to all staff on the on BPH intranet – policy and procedure site.

For the 2016 reporting period, there were eight clinical incidents and near misses associated with the correct identification of patients and for YTD 2017 there have been 4. On analysis, there have been nil adverse outcomes.

On review of the data several of the incidents and near misses involved the correct identification of patients prior to being seen by anesthetists within the Day Surgery Unit (DSU). Evidence of action was made available at the time of survey in response to this, with DSU patients having their identification bands applied by the admissions officer at the time of entry to ensure that anesthetists are able to identify all patients they see. There have been nil further incidents since changes to the process. As a result of this change, there are now three processes in place for patient identification: (i) Direct entry/ admission to the ward; (ii) Admission to the DSU; (iii) Admission to the Damascus Unit that encompasses above processes plus the inclusion of patient photograph. To support these processes, it is suggested that the organisation (BPH) develops a local guideline that clearly articulates each of these individual processes in line with HSP Policy and procedure.

The Patient Care Review Committee oversees the monitoring and evaluation of patient identification and procedure matching through clinical incident data and key performance indicators.

HSP policy and procedure uses patient identifiers and inpatient arm bands consistent with the NSQHS Standards. HSP has adopted the use of four identifiers. This was observed by surveyors during ward visits, during bedside handover and during a medication round. Due to the complexity of the patients being treated within the Damascus Unit the organisation has included as another identification process use of a photographic record for each patient which is attached to the patient's clinical record, transfer of care forms and the discharge documents.

Audits are undertaken to monitor compliance with the patient identification system as part of Healthscope's Quality KPIs (patient ID error <1.5%). Organisational performance against this KPI for the last reporting period (April-June 2017) was 0.03% equivalent to the previous reporting period and significantly below peer group.

Processes to transfer care

Surveyors observed that review of patient identification was consistently occurring during bedside handovers and during a medication round.

Discharge summaries, transfer documentation and primary health referral require the inclusion of patient identifiers.

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Processes for transfer of care have been introduced for handover of information between the orderlies and clinical staff and includes the use of correct patient identifiers. The most recent audits of compliance with the process indicate 100% compliance with patient identification

Processes to match patients and their care

HSP Correct Patient, Correct Procedure, Correct Site Policy and Procedure Ref. 2.15 provides the governance and direction to support staff. The Time Out process in theatre was verified and the Survey Team found the processes in place to be very robust and well managed. Time Out is also noted in the Endoscopy Unit.

The organisation was able to demonstrate monitoring of this checklist through monthly auditing, with results demonstrating high compliance (> 99.5% - Benchmark 90%) for all aspects of the Surgical Safety Checklist: the peri-operative, pre-incision and post procedure checklist. There have been nil clinical incidents or near misses reported for the previous two years for procedural mismatching.

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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

Action 5.1.1 Core

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

Surveyor Comment:

The organisation (BPH) develops a local guideline that clearly articulates the three individual processes for patient identification:

1. Direct entry /admission to the ward
2. Admission to the DSU
3. Admission to the Damascus Unit that encompasses above processes plus the inclusion of patient photograph in line with HSP Policy and procedure.

Surveyor's Recommendation:

No recommendation

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

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Orgcode: 720561

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Processes to support structured shift to shift clinical handovers, clinical handovers during patient transfer including theatre to PARU/ICU, discharge and escalation of patient care are based on the ISBAR tool are well written and documented. At the time of survey the organisation was in in the process of moving to ISOBAR to ensure uniformity with Healthscope (HSP). These are supported by the HSP Clinical Handover – Departmental and Intra Unit Policy and Procedure Ref 8.18, Transfer of a Patient, Inter Hospital Policy and Procedure Ref 2.49 and Clinical Deterioration, Recognising and Responding to Clinical Deterioration Ref 8.45. These documents, which clearly state the roles and responsibilities of the clinical workforce and the structure of the clinical handover, are readily accessible to all relevant staff on the on the BPH Intranet – policy and procedure site. Handover tools, including handover checklists are uniformly based on the ISOBAR format for (1) Patient Transfer and (2) Medical, Nursing and Allied Health Discharge (3) Clinical Handovers and (4) Patient escalation.

Bedside handover has been standardised across the nursing division for all three shifts to improve the quality of relevant information between staff. Within the Damascus Unit a modified version of bedside handover occurs between the morning and evening shift and at the time of 12 hour shift change overs. This has been supported by extensive staff education, with clinical handover included as part of the orientation program and within the organisation's ELMO education platform.

The organisation has implemented 'Patient Journey Boards' – Whiteboards within each patient bed side area to assist in clinical handover and to comply with the Clinical Handover policy and procedures. These 'Boards' have been well received both by the staff and patients.

An audit schedule is used to check compliance with clinical handover procedures at the clinical unit level, with these consisting of both observational and documentation audits. Results of compliance are reported to the Quality and Safety Committee. Overall, compliance for clinical handover demonstrates a 96% compliance for the May 2017 reporting period an increase of 6% from the previous period February 2017. This measure reflects a correlation of 12 audit measures. Observational audits are also undertaken to validate compliance, with results indicating a high degree of compliance. This was verified by a member of the survey team who had opportunity to attend a ward bedside clinical handover.

Evidence of improvement activities were available at the time of survey including the development of integrated patient charts, partitioned by coloured dividers within the Damascus Unit to ensure all clinically relevant documentation is available for each patient contact and during clinical handover.

Clinical handover processes

All procedures and forms regarding (i) clinical handover, (ii) Patient Transfer Form and (iii) Discharge Form are available on the BPH Intranet for staff to access. Staff education about the tools and procedures is provided at orientation, and included within the ELMO education platform.

A comprehensive audit schedule includes monitoring and evaluation of shift to shift and bedside handovers, transfer and discharge documentation, discharge summary timeliness, and surveys of patient experience. Handover incidents are monitored through RiskMan with monthly reports reviewed by the Patient Care Review Committee. There have been nil adverse events reported related to clinical handover within the last 12-month reporting period.

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Electronic Journey Boards are in the early stages of implementation across the organisation across BPH, with some clinical units utilising these to provide up-to-date patient information to assist in accurate handover with up to date clinical results available for each patient. Patient lists are able to be generated by specialist and ward location.

It is suggested that local guidelines may be developed to provide support to Medical Clinical Handover. Structured clinical handover following the ISBAR principles is undertaken within the Intensive Care Unit (ICU) between the Resident Medical Officers (RMOs) and to their consultants. The organisation is currently in the process of moving to ISOBAR to ensure uniformity of process in line with HSP.

A referral system is in place to the many community based services and includes appropriate clinical handover processes based on the requirements of the receiving agency.

Discharge summary and transfer documents all include information relevant to clinical handover. The timeliness of discharge summaries and their completion is monitored by specialty. Current completion rate last 7 days is 66.8%; this is an area noted by the organisation as an area for improvement.

Patient and carer involvement in clinical handover

Patient involvement in ward clinical handover is facilitated by bedside handover. Surveyors observed a bedside handover round and there was evidence of considerable patient engagement in the process. An hourly rounding process that is well documented is also in place. Patient and family meetings are arranged when necessary.

The organisation has implemented very comprehensive ‘Patient Journey Boards’ – Whiteboards within each patient bed side area to assist in clinical handover and to comply with the Clinical Handover procedures. As part of the Productive Wards process consumers are involved in the review of the clinical handover process. The surveyors were not advised of any audits related to the effectiveness of the care boards. The organisation is encouraged to evaluation the effectiveness of these boards as a communication tool.

The BPH Patient Information Brochure includes information regarding Clinical Bedside Handover. Latest audit results April-June 2017 indicate that 85% of patients and/or carers were involved in handover.

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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

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

BPH has instituted a blood transfusion committee with wide ranging membership involving a specialist anaesthetist, pathology representative from the blood provider, nursing staff and the blood care nurse coordinator. Minutes of the meetings are available and show full compliance with legislative requirements. The patient cohort that Brisbane Private treats is almost exclusively surgical but the case mix is wide and varied with neurosurgery and joint replacement forming a major part of cases that potentially require transfusion. The committee is very active in its monitoring of the reasons for transfusion and are able, due to its diverse makeup, to liaise in a collegiate way with all stakeholders. This has led to changes in practice and tightening of the reasons for blood transfusion. As a benefit of this the wastage rate is extremely low at less than 0.01% in their last reported audit. BPH is encouraged to continue the monitoring of blood usage and wastage as this data is important in trending of usage. All blood reactions are noted on RiskMan. Blood Safe training of staff is over 97% compliant in their latest audit results. Clinical Indicator reporting has shown no areas falling outside the acceptable range as referenced against BPH peers.

Documenting patient information

Notice is taken of the pre-admission documents that asks about previous transfusion history. The Clinical Care Coordinators at pre-admission are aware of this. An inspection of a group of patient files showed noting of pre-transfusion history. This inspection did confirm the use of the observation protocol when transfusion was started. Adverse reactions as noted are reported on RiskMan. The use of the red identity bracelet for adverse reaction is also noted. Consent for transfusion is usually carried out in the VMO rooms but BPH do have a number of printed brochures that are made available at consent on the ward.

Managing blood and blood product safety

Emergency transfusion packs are available in a designated blood refrigerator with appropriate monitoring and temperature control. There is a Massive Blood Transfusion Protocol in place. A mock training drill for this was recently carried out with excellent results shown of staff appreciation and knowledge of the system. Blood wastage is minimal with only three units of packed cells wasted in the last twelve months. As noted above the introduction of the Blood Transfusion Committee has been one of the major initiatives in continuing the exceptionally low wastage result. BPH has identified that there are occasions due to their surgical work load where rapid need of blood products is required and the onsite availability of a blood bank is being investigated.

Communicating with patients and carers

As mentioned because the majority of transfusions consents are done in the rooms of the medical practitioner the amount of material available at that source is unknown. However, BPH has a full range of documents outlining risks and reasons for transfusion and these are used as required. Audits did reveal very good consent rates for transfusion of over 93%. The institution is encouraged to continue their monitoring of all aspects of patient involvement in transfusion. It is noted that the use of so called long term consents for transfusion are not required as there are no dialysis or oncology patients treated. BPH have policies that address religious factors in transfusion.

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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

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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

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

HSP Policy on Pressure Injury Prevention and Management Ref. 8.05, Pressure Injury Prevention Risk Assessment and Management Ref 7.5 and Wound Care Assessment and Plan Ref 7.12 which are based on the AMWA 2012 Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury and Management of Prevention and Treatment of Pressure Ulcers and the best practice guidelines of the National Pressure Ulcer Advisory Panel (NPAP) 2014 and Treatment of Pressure Ulcers are available on the BPH Intranet to all staff to support and guide their practice.

Audits are undertaken to monitor compliance with systems in place to prevent pressure injuries. Pressure injury prevention and management is monitored as part of Healthscope's Corporate Quality KPIs and includes pressure injury (<0.02%) BPH April-June (0.00%). Organisational performance has been significantly below peer group for all measures for the last 12-month reporting period.

Reporting of pressure injuries is sound with pressure injury incidents monitored through RiskMan and monthly reports reviewed by the Clinical Review Committee. There have been nil adverse events reported related to pressure injuries reported within the last 12-month reporting period. Of those incidents reported YTD for 2017 nine following their review three were reclassified as skin tears. It is suggested that further education of staff regarding the recording of incidents within RISKMAN be undertaken with attention paid to the classification of pressure injuries. Processes are in place for individual incidents to be followed up at the ward level.

There was evidence available of action being taken to reduce risk where appropriate, for example introduction of Mepilex dressings for pressure injury prevention within the Day Surgery Unit.

Appropriate equipment to support the prevention and management of pressure injuries is available. Pressure relieving mattresses are available on each floor and each bed in the Intensive Care Unit has a pressure relieving mattress in place. A vast array of heel wedges and gel pads is available, of note is the theatre complex where special attention has been given to the sourcing of theatre tables and mattresses. Despite no equipment register being in place, across BPH staff indicated that they have no difficulties in accessing equipment if required. The organisation has developed and implemented Pressure Injury Prevention Brochure that includes the types of equipment available that can assist in doing this.

Preventing pressure injuries

The Waterlow pressure injury risk assessment tool has been endorsed for use across the organisation, and includes a malnutrition screening tool. It was noted at the time of survey that the HSP policy and procedure Pressure Injury Prevention and Management Ref. 8.05 includes reference to three screening and assessment tools. It is therefore suggested that a local procedure be developed that articulates with the HSP policy and procedure that clearly identifies the Waterlow tool as being the screening and assessment tool for use within BPH.

The pressure injury risk screening and assessment tool is completed on admission of all patients, where an initial score of > 15 triggers an assessment and management plan as indicated. Compliance with use of the tool is monitored through regular audits as per a defined audit schedule. Results of compliance are reported to the Quality and Safety Committee. Overall, compliance for the pressure injury prevention audit for the July 2017 reporting period indicated 96% compliance, an increase of 18% from the previous period April 2017. This measure reflects a correlation of several measures.

Observational audits are also undertaken on the longer stay wards to further assess and validate compliance with risk assessment undertaken and appropriateness of implementation strategies and plans.

Pressure relieving equipment is available with the use of a pressure mapping device to ensure appropriate equipment for each patient is used.

Managing pressure injuries

In line with the pressure injury management policies and guidelines, all inpatients receive a risk assessment which includes a full skin assessment on admission. Due to BPH status as being a leading Orthopaedic and Neurosurgery hospital, no patients with existing wounds or skin tears meet the admission criteria (for those patients undergoing scheduled surgery).

Should a patient develop a pressure injury or for those patients requiring wound management evidence-based wound management guidelines are in place based upon the Pan Pacific Guidelines and National Pressure Ulcer Advisory Panel (NPAP) 2014 through HSP policy and Procedures. A local Wound Management Manual (BPH) has been developed. It is suggested that this resource may be better utilised through direct access via the Intranet to the Pan Pacific Guidelines thereby ensuring version control.

Care plans for patients with pressure injuries are developed with the patients and their carers where appropriate and documented in the patient's health record. Compliance with the wound management policies and protocols are monitored using the audit tool.

Communicating with patients and carers

Relevant patient information is available to consumers and their carers. A Pressure Injury Prevention Brochure is available. Evidence was made available of consumer engagement in the development of the brochure.

The care planning tools in use (Pressure Injury Prevention and Risk Assessment and Management Tool) includes a section for the patient /family to sign that have been engaged in the development of the strategy being implemented. Compliance with this is monitored at the time of audit, with the most recent data indicating 93%.

Organisation: Brisbane Private Hospital
Orgcode: 720561

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

Organisation: Brisbane Private Hospital
Orgcode: 720561

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation: Brisbane Private Hospital
Orgcode: 720561

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

Surveyor Summary

Establishing recognition and response systems

Evidence is viewed that BPH has a well recognised suite of policies that enable prompt and accurate response with clinical deterioration. As part of the wider Healthscope group BPH takes part in their cluster feedback. BPH have their own rapid response working group and access to a variety of minutes of their meetings confirm policies, reactions and feedback are monitored. All incidents related to call out are reviewed and audited as to why the call out was instituted, first responders and the results of such call out. The use of the cluster groups allows feedback and updating of criteria as evidenced by the insertion of a suicide notation as a criterion for call out. Each of the specialist craft groups monitor their morbidity and mortality regularly and this can result in changes of practice. In discussion with members of the intensive care group an example was highlighted where practices in the recovery suite were reviewed and as a result certain changes in practice lead to improved patient care. It is noted that feedback to staff is well done.

Clinical Indicator reporting has shown areas falling outside the acceptable range as referenced against BPH peers. Raid response system attendances within five minutes was statistically better than the accepted time.

Recognising clinical deterioration and escalating care

There are standard observation charts noted for both adult and paediatric patients. The “between the flags” system is well recognised with clear documentation observed in various patient files. Top Cat audits were available for perusal. No deficiencies within this criterion were identified. The escalation of care is a fundamental part of the patient experience. This escalation is stressed time and again in the orientation program of new staff as well as stressed at the ward level. The use of the REACH initiative is noted. The brochures for this form part of the pre-admission process. It appeared from audits viewed that patients were aware of this. It is suggested that a laminated copy of the acronym and meaning of REACH be more prominently displayed within the patient’s room as there appears to be no publication of this apart from within the brochure handed to the patient.

Responding to clinical deterioration

There is a range of policies for escalation ranging from Clinical Review through to Code Blue response. The first responder is usually the RMO from ICU and again the use of this resource is monitored by the ICU committee. There is always an Advanced Life Support person on duty 24-hours a day. The number of VMOs with advanced life support accreditation is unknown but a review of call out has indicated no first responders as a VMO. BPH has audited their staff with Basic Life Support and have achieved over 93% compliance. An emergency number is dedicated and there are good processes in place for escalation as required.

Communicating with patients and carers

A full suite of written material is available with the pre-admission that outlines the ability of both patient and relative to escalate care as needed. Patient feedback audits showed over 95% of respondents indicated knowledge of the mechanisms of feedback. The survey team do suggest that the REACH documentation be made available as a poster or the like in each of the rooms to facilitate such escalation as needed.

Organisation: Brisbane Private Hospital
Orgcode: 720561

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:

BPH has achieved extremely high rates of Basic Life Support training of their staff with over 93% compliance.

This action is therefore fully met.

Organisation: Brisbane Private Hospital
Orgcode: 720561

Surveyor's Recommendation:

No recommendation

Action 9.6.2 Core

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

Surveyor Comment:

BPH has access to a fully trained and accredited Advanced Life Support staff member at all times. This fulfils the criteria as mandated by the commission.

Surveyor's Recommendation:

No recommendation

Risk Comments:

BP

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

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

BPH has a comprehensive falls prevention and management program in place designed to minimise the number of preventable patient falls, reduce the injuries associated with falls and to manage falls that do occur appropriately. The program is based on work done by the Australian Commission on Safety and Quality in Healthcare (2009), Guidebook for Preventing Falls and Harm from Falls in Older People: Australian Hospitals and Australian Commission on Safety and Quality in Healthcare (2005), Preventing falls and harm from falls in older people: Best practice guidelines for Australian hospitals and residential aged care facilities. To provide support to staff and assist in implementation the HSP Falls Prevention and Management Policy and Procedure Ref. 8.04 is available to staff to guide practice online via the BPH Intranet. It is evident that staff awareness and implementation of the Policy and Procedure and its supporting tools has been successful.

A set of KPIs and performance data is generated monthly and reported to the Quality Management Committee; these include: compliance with falls risk assessment audits, monitoring of falls prevention strategies and audits of medical record reviews.

Falls prevention and management with performance monitored as part of Healthscope's Corporate Quality KPI's including: Inpatient falls total (<0.3%) BPH April-June (0.14%), Rehabilitation falls total (0.5%) BPH April-June (0.17%) and Inpatient falls resulting in fracture or closed injury (0.05%) BPH April-June (0.00%). Organisational performance has been significantly below peer group for all measures for the last 12-month reporting period.

RiskMan is used to report falls-related incidents. Trend reports are generated with evidence of action being taken to address falls through falls minimisation strategies. These are reviewed at the Patient Care Review Committee. There have been nil adverse events reported related to falls injuries within the last 12-month reporting period. Most of the clinical incidents related to falls attract a classification of minor injury (32%) requiring first aid treatment and moderate injury with no adverse outcomes (50%)

Several examples of quality initiatives have been implemented which can be seen to have attributed to a decrease in the numbers of falls rates and include:

- Hourly rounding: introduced in 2016;
- Patient allocation within the Day surgery Unit;
- ISBAR and Clinical Handover and inclusion of patient risks (falls);
- Patient whiteboards to enable the notification of patient risks; and
- Mindful movement Physiotherapy Groups within the Damascus Unit.

Falls education is available to all clinical staff at orientation along with ongoing in–service opportunities.

Appropriate falls prevention equipment and devices is available, regular maintenance checks are performed to insure all equipment is readily available and safe to use.

Screening and assessing risks of falls and harm from falling

Established falls prevention strategies were evident to the survey team. All patients are screened for risk of falling on admission and regularly throughout their inpatient stay. The falls risk assessment tool (FRAT) has been endorsed as the screening tool to identify patients at risk and develop/implement plans to minimise harm. The tool is based on best practice and staff are educated on its use.

The aim is for each patient to receive a falls risk screen within 24-hours of admission. The falls risk assessment is revised should a patient's condition change, on transfer or following a fall. Their use is mandated and compliance is audited to ensure at-risk patients are appropriately assessed for falls and harm from falling.

Annual audit results July 2017 indicate high compliance with completion of the FRAT with initial falls risk assessment completed on admission (97%), FRAT tool completed (95%), interventions in place 94%. Completion of the risk assessments and appropriateness of interventions were verified and observed at the time of survey for a sample of patients that had been identified as a falls risk.

Preventing falls and harm from falling

The integrated risk assessment tool includes plans for fall prevention and these are supported by documented procedures. Equipment to prevent patients from harm from falls, such as sensor mats and high-low beds, are available to staff. Input from Pharmacy is comprehensive with the unit Pharmacist attending the ward and advising on any medications which may have implications for a falls risk. Discharge planning is comprehensive and includes risk screening and referral to allied health services or transitional care packages when required.

Communicating with patients and carers

A HSP Patient Falls Prevention Brochure '*Keeping a Step Ahead'* is available for patients and/or carers, this is provided to all patients at risk of falling and identified as high risk. It is suggested that the Patient Experience Trackers (PETS) may be used to evaluate the understanding and effectiveness of the patient information provided.

The patient care plan provides an opportunity for the patient to sign to acknowledge that they have received information on preventing falls as does the FRAT which has a section to record that a discussion has been held and make any notes or comments by patient or carer. Results from the last audit, July 2017 indicated a high compliance 94%.

Patients and carers are included in the bedside clinical handover process where falls prevention strategies can be discussed and patient awareness highlighted.

The availability of a communication board (patient journey board) in each patient room provides the opportunity for individuals to ask questions of the medical and clinical team, if they are unable to speak with them in person.

EN OWS

Organisation: Brisbane Private Hospital
Orgcode: 720561

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: Brisbane Private Hospital
Orgcode: 720561

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 11
SERVICE DELIVERY

Surveyor Summary

Information about services

BPH has a broad range of initiatives in place to inform and educate their visiting medical staff and patients about what services they are able to provide. Particularly impressive is the evidence they produced of the various education days that have been carried out for their general practitioner referral base. These have been professionally undertaken with both pre and post evaluation of the learning material provided. The use of Clinical Care Coordinators is noted in the dissemination of information. Evidence of an up to date specialist register was viewed.

Access and admission to services

The patient cohort that BPH services is predominantly elective surgery and there is virtually no unplanned admissions. Prioritisation is therefore not encountered. There are clear exclusion criteria noted and the hospital keeps within its scope of practice.

Consumer / Patient Consent

The cohort of patients that are treated at BPH are overwhelmingly elective booked surgical patients. The consent therefore is informed both for the procedure as well as full financial consent. Audits showed consent figures in the high ninety percentages. There are full policies in place to address the area of implied consent, where consent is unable to be given and where consent is not required.

Appropriate and effective care

As mentioned above the type of patient service provided tends to be elective surgical with a very large group of day only patients. BPH undertake surveys of the patient experience and these are done electronically if possible or manually if needed. Any issues are brought to the attention of the quality manager and appropriate action taken as required. It is noted that over the last 18 months BPH have employed the use of Clinical Care Coordinators. This is a very good initiative as these staff members are involved from the beginning in the pre-admission right through to discharge planning. Discharge planning involves all aspects even to liaison with Aged Care Services for review and placement.

Diverse needs and diverse backgrounds

The client population that BPH services has very little indigenous representation. It is less than 1% of the total patient load. There are no cultural issues identified. There are policies in place for the use of interpreter services as required. A full range of spiritual counsellors can be called upon if needed. Evidence is viewed of partnerships with local organisations in the support of health promotion. BPH has recently contracted with Proteus organisation to implement management promotion courses as well as consumer engagement to enhance the overall experience of both staff and patients.

Population health

BPH fulfils their legislative requirements in reporting to Queensland Health. The legionella reporting mechanism is an example of this. They have identified the need for a Da Vinci Robot for Head and Neck Cancer Surgery and are pursuing processes to start this service. Evidence is viewed of a number of initiatives in promoting better health and wellbeing. An example noted is their involvement in Mental Health Week and Safety Week in October this year.

EN OWS

Organisation: Brisbane Private Hospital
Orgcode: 720561

Information about services

Ratings

Action	Organisation	Surveyor
11.1.1	SM	SM
11.1.2	SM	SM
11.2.1	SM	SM
11.2.2	SM	SM

Access and admission to services

Ratings

Action	Organisation	Surveyor
11.3.1	SM	SM

Consumer / Patient Consent

Ratings

Action	Organisation	Surveyor
11.4.1	SM	SM
11.4.2	SM	SM

Appropriate and effective care

Ratings

Action	Organisation	Surveyor
11.5.1	SM	SM
11.5.2	SM	SM

Diverse needs and diverse backgrounds

Ratings

Action	Organisation	Surveyor
11.6.1	SM	SM

11.7.1	SM	SM
11.7.2	SM	SM

Population health

Ratings

Action	Organisation	Surveyor
11.8.1	SM	SM
11.9.1	SM	SM
11.9.2	SM	SM
11.10.1	SM	SM

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 12
PROVISION OF CARE

Surveyor Summary

Assessment and care planning

Policies and procedures are available to support the admission of patients to the organisation and plan care accordingly; these provide guidance to identifying patients at increased risk of harm and action to be taken to reduce these risks. It was identified by the survey team that the HSP Exclusion Policy for Services Not Provided Ref 2.31 was silent in respect to those criteria for paediatric Admissions thereby posing a potential risk to the organisation. This was addressed during survey with a BPH Policy developed that clearly defines the Exclusion criteria for Paediatric admissions now in place.

A comprehensive patient assessment occurs at all admission points within the health service with the nursing clinical assessment on admission including an initial screening for all patients with specific target groups such as the elderly and highlighted. Patient Feedback monitors satisfaction regarding the assessment process with results from the latest survey, June 2017 indicating a 92.4% level of satisfaction. This is comparable to previous reporting periods. The pre-registration form that is largely completed on line and verified at the time of booking in providing opportunity to screen for potential at risk patients. Compliance with this process is monitored as part of the documentation audits undertaken and evidence supports improved compliance since introduction of this audit process, and is driven through unit based improvement projects. Patients are risk assessed for falls, nutritional screening, skin integrity, pressure injury assessment and prevention and mental health issues and actions are taken to minimise any of these risks factors. The assessment tool is used to identify specific patient risks and the management of these is incorporated into the care planning process. Patients and their families are encouraged to participate in the care to ensure the care planning process meets needs. When needed, family conferences are undertaken with the patient, family and care team. Pain management is assessed on admission and closely monitored throughout the patient's journey through to discharge and further referral processes. A question is included with the Patient Experience Tracker (PET) in regard to patient’s experience and response around pain management.

Following review of the pre-admission and admission process in the Damascus Unit a position of an Intake Nurse was created to undertake pre-admission assessments, liaison with referrers, and coordination of admissions and patient flows. The survey team was advised this has improved patient assessment, management of referrals, admission processes, bed management and patient satisfaction.

Patients are identified as being of being of Aboriginal or Torres Strait Islanders (ATSI) origin or descent at the time of admission, this is recorded in WebPAS as part of the Booking in Admission Form ‘population group’. It is noted in the organisation’s demographic data that there is only a very small ATSI population (0.21%) of admitted patients. Based on this data, the organisation currently does not provide any staff training around Cultural Diversity. It is noted that a staff education program is currently being developed at Corporate level to be rolled out on Cultural Diversity with a focus of the ATSI culture.

Multidisciplinary teams play a significant role in facilitating care planning and direct care not only to patients 'at risk' but also in the more complex cases utilising both internal and external health professional service delivery agencies. Planning for discharge commences at the time of admission and management plans are developed for 'at risk' consumers with multidisciplinary input and inclusion of multi-agency services as required. BPH has implemented a Clinical Care Model across BPH to provide a more ‘patient - centric’ model of care coordination, this is supported by the appointment of three clinical care coordinators. These positions oversee the needs of each patient from pre-admission assessment, through to reviewing the patient post operatively and ensuring that timely effective discharge planning arrangement are in place.

The coordinators are also a point of contact for family members to ensure they are involved in the care planning process. Anecdotally the model and clinical care coordinator positions appear to be very effective. The organisation is encouraged to undertake a formal evaluation of the effectiveness and outcomes of the care model and service.

Compliance with both assessment and care planning processes and guidelines is monitored through clinical audit systems, case management review, the incident management system and various performance indicators. Compliance with assessment, care planning and discharge is tabled at the appropriate committee meetings.

Satisfaction with the assessment process from the patient and family perspective is assessed though the patient satisfaction survey. The latest patient satisfaction survey indicates a high degree of satisfaction with engagement in the assessment and care planning process.

Management of nutrition

Policy and guidelines are in place to support staff in the management of patient's nutritional and hydration needs consistent with the Dietitians Association of Australia's clinical practice guidelines and QLD Standards.

A Nutrition Committee is in place consisting of a group of dedicated professionals and currently meets on ad hoc basis. It is suggested that the organisation gives consideration to this Committee meeting on a more regular basis especially in light of the release of V2 of the NSQHS Standards. It is also suggested that the Committee considers mechanisms for the inclusion of consumer input into the Committee and development to various strategies driven by the Committee.

A validated screening tool for malnutrition (MUST) has been endorsed. This enables screening to occur on admission and to continue throughout the patient's admission. Once referrals to a dietitian are initiated a Nutrition Assessment Form (includes a Subjective Global Assessment) to diagnose malnutrition is completed by the Dietitian. Compliance with completion of the screening tool for malnutrition (MUST) is average > 50% with limited processes in place to verify the process for identifying those patients that have been screened as at risk and those patients that are referred appropriately. At the time of survey almost all patients considered to be at risk were automatically being referred. These processes have opportunity for improvement, with heightened vigilance of audits of compliance with the Dietitians referral form.

An education program has been developed that is currently being delivered by a Dietitian, compliance with attendance at the training has been variable across the units. It is therefore suggested that the organisation incorporates the education and training program for nutritional care and preventing malnutrition into the organisation's mandatory training program until all staff have successfully completed its requirements.

Information related to the patient's nutritional state is included in the discharge summary where relevant for the provision of ongoing care.

The organisation has opportunity to explore strategies that have the potential to assist patients with their meals that have proven to be effective in other organisations including: "protected meal times" to assist patients with their meals and use of a "red tray" for identification of patients requiring extra assistance with meals.

Organisation: Brisbane Private Hospital
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Ongoing care and discharge / transfer

A structured approach has been taken within the organisation to ensure that ongoing care and discharge is timely and effective with policies covering clinical handover, inter-hospital transfer and discharge in place and available to staff. There are processes in place to support the transition of patients from clinical areas to other service providers or discharge to home. These include bedside handover which have been implemented within each clinical unit with a focus on patient condition, current investigation reports and medications. They are supported by the Clinical Care Coordinators who assist in the appropriate assessment, care planning and facilitate discharge planning to ensure complex patients are referred to the appropriate services for ongoing care as required.

Processes for discharge are multidisciplinary and consumer focused, with a consumer/patient and family meeting held prior to discharge as appropriate. Discharge planning which starts at admission, fosters a team approach to consumer/patient care. There are weekly Case Conference meetings for patients within the Rehabilitation Ward and Long Stay Ward (Neuro) which assist in ensuring appropriate services are available to support patients in the community on their discharge from hospital. The Clinical Care Coordinators assists in the appropriate assessment, care planning and facilitate discharge planning to ensure complex patients are referred to the appropriate services for ongoing care as required. In the Damascus unit multidisciplinary case conferences are regularly conducted for all inpatients and patients attending Day Programs includes discharge planning.

BPH Performance highlights for July 2016 to June 2017 indicate the effectiveness of the organisation's discharge and referral services. Data indicates that in this period there were 268 referrals made to Home Support Services (HSS) from BPH to facilitate a streamlined supported discharge process of an average age of 69 years. Of those patients referred for care to the HSS over ten different clinical disciplines were involved with delivering care to patients and 94% of the patients were discharged to independence following their HSS episode.

Discharge information is sent to future care providers with patient consent ensuring continuity of care. A range of services and programs which can be tailored to the consumer's specific needs are available to assist patients to manage at home.

Discharge/transfer documentation is provided to the patient and to the referrer/GP however compliance with completion of medical discharge summaries April-June 2017 was 66.8% the organisation is encouraged to work with medical practitioners to ensure this documentation is routinely provided to patients on discharge.

Follow up phone calls are made within seven days following discharge from the Day Surgery Unit (DSU). Compliance with this at the time of survey was 89% (target 90%).

End-of-life care

The organisation has a HSP Policy and Procedure in place to manage the Deceased Patient - Last Office and Advanced Care Planning with supporting guidelines and resources, these are available for staff on the Healthscope Intranet. In discussion with staff it was identified at the number of deaths were very small and as such reliance of the HSP Policy and procedure to guide their practice was high. Copies of Advance Care Plans provided by patients are retained within the medical record and notified to the clinical team. There are dedicated palliative care beds if required.

Staff have been educated regarding Advanced Care Planning and Plans. Compliance with documentation is included within the organisation's annual audit program. Documentation available for the patient and family is extensive, clear and well-presented.

EN OWS

Organisation: Brisbane Private Hospital
Orgcode: 720561

Assessment and care planning

Ratings

Action	Organisation	Surveyor
12.1.1	SM	SM
12.1.2	SM	SM
12.2.1	SM	SM
12.2.2	SM	SM
12.3.1	SM	SM
12.4.1	SM	SM

Management of nutrition

Ratings

Action	Organisation	Surveyor
12.5.1	SM	SM
12.5.2	SM	SM
12.6.1	SM	SM
12.6.2	SM	SM
12.6.3	SM	SM
12.7.1	SM	SM
12.7.2	SM	SM

Ongoing care and discharge / transfer

Ratings

Action	Organisation	Surveyor
12.8.1	SM	SM
12.8.2	SM	SM
12.8.3	SM	SM
12.9.1	SM	SM
12.10.1	SM	SM
12.10.2	SM	SM
12.10.3	SM	SM

Organisation: Brisbane Private Hospital
Orgcode: 720561

End-of-life care

Ratings

Action	Organisation	Surveyor
12.11.1	SM	SM
12.11.2	SM	SM
12.12.1	SM	SM
12.12.2	SM	SM

Organisation: Brisbane Private Hospital
Orgcode: 720561

STANDARD 13
WORKFORCE PLANNING AND MANAGEMENT

Surveyor Summary

Workforce planning

Workforce planning is undertaken at the BPH local level on an annual basis and includes development of workforce profiles required for projected activity. Annual financial planning includes workforce skill mix, EFT and budget. The workforce profile is closely monitored by the BPH Executive and HSP Corporate office, and includes ratio for staff mix, staff turnover, absenteeism, overtime, agency usage. Plans are in place for recruitment of additional staff for opening of additional beds and theatres in the new building currently under construction. The Executive Management Team ensure safe work hours and rostering are maintained, and include flexible working arrangements, transition from fulltime to part-time work, and use of casual staff. Contingency plans are in place to maintain safe patient care. Workforce attraction strategies are used and include supporting clinical placements for undergraduate nursing students and provision of structured programs for new nursing graduates.

Recruitment processes

BPH's recruitment/selection/appointment processes occur within the framework of HSP policies and include advertising, interviews, verification of qualifications and registrations, licences, insurance coverage and professional development activities and reference checks. Appropriate processes are established for ensuring that agency and locum workforce are screened and meet the standards required by THHS prior to commencement of employment. The credentialling system is well- developed and is covers re-credentialling, scope of practice and temporary appointments, and is regularly audited.

Volunteer recruitment/appointment, is overseen by a Volunteer Coordinator. All newly appointed volunteers attend an orientation program. Volunteers spoken to by the survey team indicated high levels of job satisfaction and felt valued by the Hospital Executive and staff.

Continuing employment and development

Personnel records are securely maintained and include training and professional development activities and copies of the performance reviews which are done annually utilising a HSP performance review tool. Clinician's performance is monitored and linked to the credentialling system. Performance issues are dealt with as they arise by Management and the MAC with support from HSP Corporate office and the Human Resource Team RiskMan is used to record any complaints regarding clinicians and supported with guidelines for dealing with such events and support the Human Resource Team is readily available Volunteers.

Employee support and workplace relations

Communication of information to employees and volunteers regarding their rights and responsibilities occurs with a framework of HSP policies/procedures and is included in role descriptions, terms and conditions attached with letters of offer and information provided at employee/volunteer commencement. Mechanisms are established for resolution of disputes and grievances and for recognition and celebration of the organisation's workforce and volunteer achievements.

The 2016 Staff survey "Your Voice Counts" has been associated with re-establishment of Staff Engagement Committee and development and implementation of action plan for 5 key areas of concern.

Processes have been strengthened for executive consultation/communication with the workforce and includes implementation of ‘A Not So Undercover Boss’ initiative where the Executive work in designated clinical and non-clinical areas alongside staff for 2 hour periods. The survey team was advised that this initiative was well received by the workforce.

A BPH Wellness Support program is in operation and is overseen by a Wellness Committee which meets monthly. The focus is on engaging the workforce in healthy lifestyles and includes a wide range of initiatives such as introduction of healthy food in the BPH canteen with low carbonate options, exclusion of soft drinks; sponsoring of workforce teams in the Bridge to Brisbane Fun Run, Installation of bike cages/lockers and showers for BPH workforce use, and participation in mental health women’s health activities. The organisation is congratulated on this program.

All staff and their families have access to the Employee Assistance Program, which is provided by and external provider. Communication regarding EAP is distributed to staff via emails, posters. Reports on EAP usage are provided by the external provider to the BPH Executive.

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Workforce planning

Ratings

Action	Organisation	Surveyor
13.1.1	SM	SM
13.1.2	SM	SM
13.2.1	SM	SM
13.3.1	SM	SM

Recruitment processes

Ratings

Action	Organisation	Surveyor
13.4.1	SM	SM
13.5.1	SM	SM
13.5.2	SM	SM
13.6.1	SM	SM

Continuing employment and development

Ratings

Action	Organisation	Surveyor
13.7.1	SM	SM
13.7.2	SM	SM
13.8.1	SM	SM
13.8.2	SM	SM
13.8.3	SM	SM
13.9.1	SM	SM
13.9.2	SM	SM

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Employee support and workplace relations

Ratings

Action	Organisation	Surveyor
13.10.1	SM	SM
13.10.2	SM	SM
13.11.1	SM	SM
13.12.1	SM	SM
13.13.1	SM	SM

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STANDARD 14
INFORMATION MANAGEMENT

Surveyor Summary

Health records management

BPH has processes and policies in place that fulfil all legislative requirements pertaining to health record management and storage. Patient records are paper based and are freely available at point of care. BPH keep patient records on site for two years. Any records older than this time frame are kept off site with a commercial organisation Iron Mountain. Access to these notes is easy and seamless even to gaining them within the hour if so needed. The notes are tracked electronically through WebPAS and the staff also have a paper trail to back up WebPAS. Under Queensland Health guidelines clinical records are kept for the designated mandatory time span and then confidentially destroyed. A unique identifier is allocated to each patient. It is noted that with the introduction of the e-admission process that at times another identifier is generated. BPH is aware of this and have instituted checks and balances whereby the personal details of the patient are removed and they are then tracked using their birth date. This gets over any differences that may be encountered with different spelling etc. of names. Clinical Coding and Reporting times are acceptable. Even though they fall outside the so called gold standard of 48hrs, it is Healthscope policy that accuracy is of greater importance. Training is undertaken for medical record staff through eLearning as well as a dedicated training day with certificate of training being presented at the end of this time. Access to patient information is available and usually for simple forms such as discharge summary etc. these are free of cost. Third party access is available and regulated. The use of electronic pre-admission has been rolled out and the take up rate is approximately 53%. The use of an electronic signature is noted. Before being able to use this admission mechanism, the patient needs to register and a secure SMS message is sent with a password to enable the process to commence.

Corporate records management

Healthscope have protocols in place for corporate management of records that BPH adhere to. There are significant IT checks in place to prevent unauthorised access to date and files. As part of their strategy BPH has a vibrant research area in their partnership with the Hand and Upper Limb research institute located on their campus. BPH is a part of the wider Healthscope company so all their requirements regarding such as retention for tax records, contracts etc. are met. Those records are stored off site at Iron Mountain. Training is provided for coding staff and is up to date as per the ICD-10-AM standards.

Collection, use and storage of information

Medical records are stored on site in a dedicated records area which is secure and has authorisation codes to gain access. Records of patients are kept in this facility for two years and then decanted to an offsite storage facility managed by Iron Mountain. Records are easily sourced from this off site as required and the turnaround time can be a little as an hour. The use of cluster groups within Healthscope allow transfer of data between other sites. The use of transfer of data to various medical practitioners via email is noted as well as the use of fax machines and the like.

Information and communication technology

BPH has instituted an electronic pre-admission process within the last 18 months. They have resourced this well and have identified areas requiring attention and have modified this. An area of patient identification numbers being duplicated has been highlighted and addressed with a change in focus onto the birth date as the primary identifier for generation of their unique identifier.

The access to the IT system is password protected as well as level of authorisation protected.

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A log of the use of the IT system is available for review if necessary. Access to the medication areas on the wards are also swipe card protected with use confined to staff needing to use these areas. Medical Practitioners are precluded from having access to these areas. Software for IT is sourced through the corporate structure of the parent company, Healthscope.

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Health records management

Ratings

Action	Organisation	Surveyor
14.1.1	SM	SM
14.2.1	SM	SM
14.3.1	SM	SM
14.3.2	SM	SM
14.4.1	SM	SM

Corporate records management

Ratings

Action	Organisation	Surveyor
14.5.1	SM	SM

Collection, use and storage of information

Ratings

Action	Organisation	Surveyor
14.6.1	SM	SM
14.6.2	SM	SM
14.7.1	SM	SM
14.8.1	SM	SM

Information and communication technology

Ratings

Action	Organisation	Surveyor
14.9.1	SM	SM
14.9.2	SM	SM

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STANDARD 15
CORPORATE SYSTEMS AND SAFETY

Surveyor Summary

Strategic and operational planning

The planning process at BPH includes a Strategic Plan (2015-2018) and Quality Plan (2016-2017) that incorporate the organisation's vision, missions and values, strategic goals objectives and identify priority areas for care, service delivery and facility development, and effective use of resources. The Strategic Plan is set within HSP Vision and strategic direction and policies and is developed in consultation with key stakeholders and HSP State and Corporate Executive. The planning process also includes financial plans that cover objectives, budgets, revenue and expenditure targets, and projected activity. Plans are subject to ongoing monitoring of achievements and performance against targets and KPIs by the Executives/ Department/Unit managers and HSP Corporate. The General Manager submits an end of month report to the State Manager including an update on the progress of the Strategic Plan. Communication to the stakeholders on progress and achievements occurs via, committee meetings, workforce forums, newsletters and memos and GP liaison activities. Information on progress on the hospital's expansion program and in construction of the new building is communicated to stakeholders via planning and project meetings and to the community via the BPH website.

A positive organisation culture at BPH is evident and is supported with policies, adherence to a code of conduct and performance development and review. An HSP staff survey "Your Voice Counts" in 2016 has been associated with re-establishment of Staff Engagement Committee and development and implementation of action plan for 5 key areas of concern. The survey team were impressed with the high level of teamwork that was apparent throughout BPH.

Systems and delegation practices

HSP sets the Delegations of Authority for BPH and these are supported by HSP policy and controls for procurement and staff recruitment/ appointments. The compliance with delegations is rigorously monitored through the BPH Financial Manager, HSP State Manger and Corporate Office.

The BPH Committee structure and reporting lines are clearly documented. All committees have Terms of Reference which include details of membership, meeting frequency, scope and minutes production. The performance and terms of reference of all committees are reviewed annually. Agendas and minutes of committees are well documented.

Should BPH need assistance in dealing with ethical issues they have access to the Corporate Ethics Committee and the BPH Low Risk Ethics Committee.

BPH has very good financial management systems in place that report to HSP Corporate office as well as providing managers at the local level with reports to monitor financial performance. Budgets are reviewed annually and approved by Corporate Office. All departments/units within BPH develop annual budgets in consultation with Financial Manager and General Manager. The organisation is required to provide monthly financial reports to the Corporate Office and complete and submit a HSP financial management questionnaire six monthly. HSP external financial audits are conducted six monthly.

External Service Providers

HSP policy provides the framework to guide the engagement of contractors in a range of clinical and non-clinical service areas.

A pre-qualification system is in place to ensure that contractors' credentials are verified and kept current through the contract management databases which are maintained by the Executive Suite and the Maintenance Department. KPIs are incorporated in contracts as required, for example pharmacy, imaging, security, preventative maintenance, linen waste management and are reported on. Regular meetings are held with contractors/ suppliers, the General Manager and Facility Manager. All contracts are evaluated prior to expiration and renewal, with any contractor performance issues being addressed as they occur.

Building and equipment service contractors are required to complete onsite registration and checklist of pre-requisite work health and safety requirements prior to proceeding to the work area. This is controlled by the Maintenance Department.

Research Governance

Brisbane Private Hospital is involved with the Brisbane Hand and Upper Limb research institute which is based on the campus of BPH. They have their own ethics committee that oversees low risk research applications which mainly are involved and are non-invasive and usually incorporate patient feedback. This committee has guidelines for application that effectively rule out any chance of patient harm for the application to be deemed low risk. BPH uses external ethic committees for applications deemed medium to high risk. They have used the Mater Hospital Ethics Committee as well as Queensland University. Evidence is viewed of a number of examples of low risk programs being undertaken. The Medical Advisory Committee is notified of any pending applications and they have the right to contribute to the discussion around each application.

Safety management systems

The BPH's safety management systems are robust and are underpinned by well-documented policies/procedures that are linked to the legislation and relevant Australian Standards, and show evidence of being subjected to review. The WH&S Committee has employee representation from all areas of the organisation plus management representatives. Minutes of the meetings of the Committee are made available electronically and displayed on notice boards for staff information. The WHS Committees contribute to the evaluation of WHS performance through completion of audits and risk assessments, monitoring WHS incidents, and following up to ensure improvements have been implemented. Education of WHS representatives to their WHS role occurs informally during participation in WHS Committee activities. During the survey, an action plan was developed to develop and implement a formal training program via a BPH Training Package in consultation with WHS State Manager with a target date of completion of training by April 2018.

All staff are responsible to assist in completion of inspections to identify hazards and report potential and actual hazards to their WHS representative and their manager. Incident and near misses are reported in RiskMan. The risk register incorporates risks identified at functional sites and from incident reporting and is subject to regular review.

There was evidence that staff, visitors and contractors are educated on workplace health and safety. Robust processes are in place to ensure workplace safety is a priority for contractors working on site. Staff are educated in risk and hazard identification and risk mitigation strategies, and safe work practices. Health and Safety Environmental Inspections are completed electronically using TopCat by WHS representatives and results tabled at Heads of Department and WHS meetings.

Manual Handling training includes use of an eLearning education program and a practical component which is supported with manual handling trainers and competency assessments. Evidence provided shows 98% of the staff have completed the mandatory eLearning package.

There are very good supplies of manual handing equipment and a well-developed injury management program. A “Take 5” Program developed by the WHS Coordinator has been implemented throughout the organisation and requires staff to undertake risk assessments before commencement of work. This initiative together with the other WHS injury prevention and management activities has been associated with a significant reduction is BPH workplace injuries and lost time injuries in 2016/2017.

A reduction of 19% in the BPH injury index and 33% reduction in manual handling injuries was reported. The organisation is congratulated on this achievement.

Safe operating procedures are widely displayed at point of work and processes are established for ongoing review. Storage and handling of hazardous substances and chemicals are managed in accordance with relevant standards and guidelines. A register of dangerous goods and hazardous substances is maintained. Ecolab is used for maintenance of currency of Ecolab related information and assists in the management of chemicals and staff training. Material safety data sheets are available and provide staff with current information in relation to product storage and handling.

There is a well-developed radiation safety management system in place covering medical imaging and laser equipment. There are contracted Radiation Safety Officer and laser safety officers, Radiation Safety and Protection and Laser Safety Plans approved by QLD in 2016. The Radiation and Laser Safety Committee meets quarterly. Evidence provided showed currency of required licences and registrations of relevant staff. All radiation safety equipment is operated and maintained by external contractors.

Inventory/Compliance Testing/Assessment Reports for Radiation and Laser are available. Radiation badges are monitored quarterly to assess levels of exposure. No instances of excess workforce exposure were reported. Lead aprons are provided, checked, and replaced as required. No radioactive substances are stored on-site.

Buildings, plant and equipment

The system for procurement management of supplies well-addressed, with close monitoring of stock levels, timeliness of delivery and safe storage of supplies and efficiency. Corporate procurement oversees contracts, supply consumables, medical devices and is managed by a state based supply centre. Medical loan sets instruments and consumables are managed by the Operating Theatre and CSSD.

The preventative maintenance program covers facilities and equipment and is well-developed. It is overseen by the BPH Maintenance Department supported with a Site Preventative Maintenance Plan and a preventative maintenance software package KwikLook. Processes are in place for prioritising work and addressing urgent requests and for monitoring outstanding work. A comprehensive process is in place to ensure that biomedical equipment is monitored and maintained. All equipment, gases, machines and appliances are recorded, monitored and subject to regular testing. Manufacturers servicing and testing specifications are used as the minimum requirement for all maintenance scheduling tasks. Provision exists for the identification and evaluation of risks and the reporting and management of these through the risk management system.

The facility has been undergoing extensive capital redevelopment to upgrade facilities which includes a ward refurbishment project and increased provision of private rooms, installation of two new CSSD lifts. The major development project of a multi-story new hospital wing at the front of the hospital which is currently in progress and incorporates 26 acute surgical beds. Four additional operating theatres is planned, two of which are proposed to be commissioned immediately on completion of construction. Regularly meetings are being held with the Major Project Committee, the builders, representatives from HSP Corporate, the BPH Executive and Facilities Manager.

In planning the new facilities safety, risk, access, patient flow and environmental issues have been considered. Review/ revision of parking facilities has occurred and disabled parking facilities relocated to an undercover area, and temporary relocation of front entrance and admissions lounge. Way finding kiosks have been installed in existing buildings and are to be installed in the new building. The survey team was advised that actions were being taken to ensure that minimisation of ligature points are incorporated in the areas to accommodate Damascus Drug & Alcohol inpatient and Day Programs in the new building.

Overall, BPH facilities are well-maintained and provide a, safe and welcoming environment for patients, visitors and staff.

Emergency and disaster management

BPH's emergency and disaster management systems are well established and supported by a Disaster Management and Recovery Policy and well-documented BPH Emergency Procedures Manual and Disaster Management plan that incorporate contingencies for foreseeable emergencies and business continuity. A BPH Pandemic Influenza Management Plan provides a strategic overview of the activities undertaken to ensure the organisation is adequately prepared for an influenza pandemic. All documents show evidence of review and currency of information.

There is evidence that fire inspections of BPH buildings had been completed by an authorised external provider within the required timeframes, all recommendations addressed and compliance with required standards demonstrated. Fire equipment is well maintained and subject to regular checks. Emergency Fire evacuation plans are strategically located throughout the buildings. Records showing 98% workforce compliance with mandatory emergency management training. Wardens and senior staff are orientated to their roles.

The organisation is very well prepared to make a timely and effective response to internal and external emergencies/disasters. Simulated emergency exercises are conducted and focus on fire management. It is suggested that the simulation exercises be expanded to include major disasters and include scheduling of a full Emergency Simulation exercise and evaluation of the hospital-wide performance.

Medical emergency equipment is appropriately maintained throughout facilities. Emergency trolleys are subject to routine checking and ongoing review with a view to standardisation of contents. Adult and paediatric emergency equipment is available.

Physical and personal security

The security management system is well- developed and supported with HSP policies, workforce education, RiskMan risk register and incident reporting, audits of compliance and monitoring of performance. A BPH Security Management Plan 2017 and an action plan are available following assessment of facility-wide security in 2017 undertaken using a HSP environmental and security risk assessment tool. Evidence was available showing that areas identified as requiring improvement are being addressed and as requiring incorporated in the new construction.

An external provider provides onsite security services 1800 to 0600 hrs. seven days per week and monitors CCTV cameras, provides patrols and escorts staff to car parks. Procedures are established for lockdown at 2100hrs. The organisation advised that consideration is be given to expansion to 24 hrs. when the new building is completed.

Systems are established for key controls swipe and review and monitoring of door access codes, and review of CCTV footage and security incidents. Security is a standing item on the WHS Committee.

Education for managing violent and aggressive behaviour is covered at orientation and included as part of mandatory training, with records showing very high levels of staff compliance. Duress alarms are available in the Damascus unit, and other areas such as Front reception.

Waste and environmental management

BPH waste management is supported with HSP and BPH policies and a BPH Waste Management Plan. External contractors are engaged handle and clinical and general waste. Clinical waste is secured securely prior to pick up. General waste is recycled. Waste areas are well sign posted for easy identification and safety awareness. There is evidence that there are systems in place to manage efficient use and resource sustainability general waste use of energy, water and reduction in carbon emissions.

These aspects are being of energy, water, and reduction of carbon emissions be reviewed. Several strategies have been introduced to reduce general waste and increase recycling and is being led by the BPH Waste Management and Green Committees. Evidence was available showing reports from the external waste contractor indicated 14% reduction in waste going into landfill due to recycling.

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Strategic and operational planning

Ratings

Action	Organisation	Surveyor
15.1.1	SM	SM
15.1.2	SM	SM
15.1.3	SM	SM
15.2.1	SM	SM
15.2.2	SM	SM

Systems and delegation practices

Ratings

Action	Organisation	Surveyor
15.3.1	SM	SM
15.4.1	SM	SM
15.5.1	SM	SM
15.6.1	SM	SM
15.7.1	SM	SM
15.8.1	SM	SM

External Service Providers

Ratings

Action	Organisation	Surveyor
15.9.1	SM	SM
15.9.2	SM	SM

Research Governance

Ratings

Action	Organisation	Surveyor
15.10.1	SM	SM
15.10.2	SM	SM
15.11.1	SM	SM
15.11.2	SM	SM

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Safety management systems

Ratings

Action	Organisation	Surveyor
15.12.1	SM	SM
15.13.1	SM	SM
15.13.2	SM	SM
15.13.3	SM	SM
15.14.1	SM	SM

Buildings, plant and equipment

Ratings

Action	Organisation	Surveyor
15.15.1	SM	SM
15.15.2	SM	SM
15.16.1	SM	SM
15.16.2	SM	SM
15.17.1	SM	SM

Emergency and disaster management

Ratings

Action	Organisation	Surveyor
15.18.1	SM	SM
15.19.1	SM	SM
15.20.1	SM	SM
15.20.2	SM	SM

Physical and personal security

Ratings

Action	Organisation	Surveyor
15.21.1	SM	SM
15.21.2	SM	SM
15.22.1	SM	SM
15.22.2	SM	SM

15.23.1	SM	SM

Waste and environmental management

Ratings

Action	Organisation	Surveyor
15.24.1	SM	SM
15.25.1	SM	SM
15.26.1	SM	SM

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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 unexpected deterioration in health status	SM	SM
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	SM	SM

	response to complaints		
1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	SM	SM
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	SM	SM

	role		
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
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	SM	SM

	• processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • 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	MM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	MM
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	MM
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	SM	SM

	protocols and use is provided for the workforce who perform procedures with invasive devices		
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	SM	SM

	• 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		
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	SM	SM

	regularly assessed		
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

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

Organisation: Brisbane Private Hospital
Orgcode: 720561

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, treatment or investigation is regularly monitored	SM	SM
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

Organisation: Brisbane Private Hospital
Orgcode: 720561

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 consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
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,	SM	SM

	collection and transport of blood and blood products is undertaken		
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

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	SM	SM

	presentation		
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 periodically audited to identify at-risk patients with documented skin assessments	SM	SM
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	SM	SM

	and response systems		
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 • communication about clinical deterioration	SM	SM
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 system	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	SM	SM

	are regularly reviewed		
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

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	SM	SM

	strategies for patients at risk of falling and management plans to reduce the harm from falls		

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

Service Delivery

Information about services

Action	Description	Organisation's self-rating	Surveyor Rating
11.1.1	There is evidence of evaluation and improvement of the quality of information provided to consumers / patients and the community about: • services provided by the organisation • access to support services, including advocacy.	SM	SM

11.1.2	The organisation’s processes for disseminating information on healthcare services are evaluated, and improved as required.	SM	SM
11.2.1	Healthcare providers within the organisation have information on relevant external services.	SM	SM
11.2.2	Relevant external service providers are provided with information on the health service and are informed of referral and entry processes.	SM	SM

Access and admission to services

Action	Description	Organisation's self-rating	Surveyor Rating
11.3.1	The organisation evaluates and improves its system for admission / entry and prioritisation of care, which includes: • documented processes for prioritisation • clear inclusion and/or exclusion criteria • management of waiting lists • minimisation of duplication • utilisation of information in referral documents from other service providers received on admission of the consumer / patient • management of access block.	SM	SM

Consumer / Patient Consent

Action	Description	Organisation's self-rating	Surveyor Rating
11.4.1	The organisation has implemented policies and procedures that address: • how consent is obtained • situations where implied consent is acceptable • situations where consent is unable to be given • when consent is not required • the limits of consent.	SM	SM
11.4.2	The consent system is evaluated, and improved as required.	SM	SM

Appropriate and effective care

Action	Description	Organisation's self-rating	Surveyor Rating
11.5.1	The organisation ensures appropriate and effective care through: • processes used to assess the appropriateness of care • an evaluation of the appropriateness of services provided • the involvement of clinicians, managers and consumers / patients in the evaluation of care and services.	SM	SM
11.5.2	Policy / guidelines are implemented that address the appropriateness of the setting in which care is provided including when consumers / patients are accommodated outside the specialty ward area.	SM	SM

Diverse needs and diverse backgrounds

Action	Description	Organisation's self-rating	Surveyor Rating
11.6.1	The organisation obtains demographic data to: • identify the diverse needs and diverse backgrounds of consumers /	SM	SM

	patients and carers • monitor and improve access to appropriate services • improve cultural competence, awareness and safety.		
11.7.1	Policies and procedures that consider cultural and spiritual needs are implemented to ensure that care, services and food are provided in a manner that is appropriate to consumers / patients with diverse needs and from diverse backgrounds.	SM	SM
11.7.2	Mechanisms are implemented to improve the delivery of care to diverse populations through: • demonstrated partnerships with local and national organisations • providing staff with opportunities for training.	SM	SM

Population health

Action	Description	Organisation's self-rating	Surveyor Rating
11.8.1	Performance measures are developed, and quantitative and/or qualitative data collected, to evaluate the effectiveness / outcomes of health promotion programs and interventions implemented by the organisation.	SM	SM
11.9.1	The organisation identifies and responds to emerging health trends.	SM	SM
11.9.2	The organisation meets its legislative requirements for reporting on public health matters.	SM	SM
11.10.1	There is evidence of evaluation and improvement of strategies to promote better health and wellbeing, which include: • undertaking opportunistic health promotion / education strategies in partnership with consumers / patients, carers, staff and the community • providing education, training and resources for staff to support the development of evidence-based health promotion programs and interventions.	SM	SM

Provision of Care

Assessment and care planning

Action	Description	Organisation's self-rating	Surveyor Rating
12.1.1	Guidelines are available and accessible by staff to assess physical, spiritual, cultural, psychological and social, and health promotion needs.	SM	SM
12.1.2	Guidelines are available and accessible by staff on the specific health needs of self-identified Aboriginal and Torres Strait Islander consumers / patients.	SM	SM
12.2.1	The assessment process is evaluated to ensure that it includes: • timely assessment with consumer / patient and, where appropriate, carer participation • regular assessment of the consumer / patient need for pain / symptom management • provision of information to the consumer / patient on their health status.	SM	SM
12.2.2	Referral systems to other relevant service providers are evaluated, and improved as required.	SM	SM

12.3.1	Care planning and delivery are evaluated to ensure that they are: • effective • comprehensive • multidisciplinary • informed by assessment • documented in the health record • carried out with consumer / patient consent and, where appropriate, carer participation.	SM	SM
12.4.1	Planning for discharge / transfer of care is evaluated to ensure that it: • commences at assessment • is coordinated • consistently occurs • is multidisciplinary where appropriate • meets consumer / patient and carer needs.	SM	SM

Management of nutrition

Action	Description	Organisation's self-rating	Surveyor Rating
12.5.1	Policy / guidelines for: • delivery of nutritional care • prevention of malnutrition • assessment of need for assistance with meals are consistent with jurisdictional guidelines, adapted to local needs and implemented across the organisation.	SM	SM
12.5.2	The organisation’s strategic and coordinated approach to delivering consumer / patient-centred nutritional care is evaluated, and improved as required.	SM	SM
12.6.1	Food, fluid and nutritional care form part of an intervention and clinical treatment plan.	SM	SM
12.6.2	Relevant healthcare providers use an approved nutrition risk screening tool to assess consumers / patients: • on admission • following a change of health status • weekly thereafter and referrals to nutrition-related services occur when needed.	SM	SM
12.6.3	The adequacy of consumer / patient nutrition is actively monitored and reported, and improvement is made to the nutritional care as required.	SM	SM
12.7.1	A multidisciplinary team oversees the organisation’s nutrition management strategy to ensure that provision of food and fluid to consumers / patients is consistent with best-practice nutritional care.	SM	SM
12.7.2	Education programs for relevant staff about their roles and responsibilities for delivering best-practice nutritional care and preventing malnutrition are evaluated, and improved as required.	SM	SM

Ongoing care and discharge / transfer

Action	Description	Organisation's self-rating	Surveyor Rating
12.8.1	Discharge / transfer information is discussed with the consumer / patient and a written discharge summary and/or discharge	SM	SM

	instructions are provided.		
12.8.2	Arrangements with other service providers and, where appropriate, the carer are made with consumer / patient consent and input, and confirmed prior to discharge / transfer of care.	SM	SM
12.8.3	Results of investigations follow the consumer / patient through the referral system.	SM	SM
12.9.1	Formalised follow up occurs for identified at-risk consumers / patients.	SM	SM
12.10.1	Formal processes for timely, multidisciplinary care coordination and/or case management for consumers / patients with ongoing care needs are evaluated, and improved as required.	SM	SM
12.10.2	Systems for screening and prioritising consumers / patients with ongoing care needs who regularly require readmission are evaluated, and improved as required.	SM	SM
12.10.3	Education is provided to consumers / patients requiring ongoing care and, where appropriate, to their carers.	SM	SM

End-of-life care

Action	Description	Organisation's self-rating	Surveyor Rating
12.11.1	Policy and procedures for the management of consumer / patient end-of-life care consistent with jurisdictional legislation, policy and common law are available and staff receive relevant education.	SM	SM
12.11.2	There is policy / guidelines for supporting staff, consumers / patients and carers involved in organ and tissue donation.	SM	SM
12.12.1	Access to and effectiveness of end-of-life care is evaluated, including through the use of clinical review committees.	SM	SM
12.12.2	A support system is used to assist staff, relatives, carers and consumers / patients affected by a death.	SM	SM

Workforce Planning and Management

Workforce planning

Action	Description	Organisation's self-rating	Surveyor Rating
13.1.1	Workforce management functions and responsibilities are clearly identified and documented.	SM	SM
13.1.2	The workforce policy, procedures, plan, goals and strategic direction are regularly reviewed, evaluated, and improved as required.	SM	SM
13.2.1	Contingency plans are developed to maintain safe, quality care if prescribed levels of skill mix of clinical and support staff are not available, and in order to manage workforce shortages.	SM	SM
13.3.1	The system for managing safe working hours and fatigue prevention is evaluated, and improved as required.	SM	SM

Recruitment processes

Action	Description	Organisation's self-rating	Surveyor Rating
13.4.1	The organisation-wide recruitment, selection and appointment systems are evaluated, and adapted to changing service needs where	SM	SM

	required.		
13.5.1	Recruitment processes ensure adequate staff numbers and that the workforce has the necessary licences, registration, qualifications, skills and experience to perform its work.	SM	SM
13.5.2	The credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians, which is consistent with national standards and guidelines and with organisational policy, is evaluated, and improved as required.	SM	SM
13.6.1	The volunteer recruitment system supports an adequate number and mix of volunteers to complement the work undertaken by paid staff.	SM	SM

Continuing employment and development

Action	Description	Organisation's self-rating	Surveyor Rating
13.7.1	Accurate and complete personnel records, including training records, are maintained and kept confidential.	SM	SM
13.7.2	There is a system to document training for staff and volunteers which is identified as necessary by the organisation.	SM	SM
13.8.1	The performance assessment and development system includes: • review of position descriptions • review of competencies • monitoring of compliance with published codes of professional practice • assessment of learning and development needs • provision of adequate resources for learning and development • management of identified performance needs.	SM	SM
13.8.2	Ongoing monitoring and review of clinicians' performance is linked to the credentialling system.	SM	SM
13.8.3	The performance assessment and development system is evaluated through appropriate stakeholder consultation, and improved as required.	SM	SM
13.9.1	Processes are in place for managing a complaint or concern about a clinician, and there is evidence that they have been used.	SM	SM
13.9.2	Processes are in place for managing a complaint or concern about a member of staff, including contracted staff and volunteers, and there is evidence they have been used.	SM	SM

Employee support and workplace relations

Action	Description	Organisation's self-rating	Surveyor Rating
13.10.1	The workplace rights and responsibilities of management, staff and volunteers are clearly defined and communicated.	SM	SM
13.10.2	Managers take action on at-risk behaviour of staff and volunteers.	SM	SM
13.11.1	There is a consultative and transparent system to identify, manage and resolve workplace relations issues which is evaluated, and improved as required.	SM	SM
13.12.1	Strategies to: • motivate staff • acknowledge the value of staff • support flexible work practices	SM	SM

	are evaluated with staff participation, and improved as required.		
13.13.1	Performance measures are used regularly to assess staff access to an employee assistance program and to evaluate the staff support services, and improvements are made as required.	SM	SM

Information Management

Health records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.1.1	Health records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • timely and accurate retrieval of records stored on or off site, or electronically • appropriate retention and destruction of records • training for relevant staff in health records management.	SM	SM
14.2.1	The system for the allocation and maintenance of the organisation-specific consumer / patient identifier, including a process for checking multiple identifiers, is evaluated, and improved as required.	SM	SM
14.3.1	Healthcare workers participate in the analysis of data including clinical classification information.	SM	SM
14.3.2	Clinical coding and reporting time frames that meet internal and external requirements are evaluated, and improved as required.	SM	SM
14.4.1	Consumers / patients are given advice / written guidelines on how to access their health information, and requests for access are met.	SM	SM

Corporate records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.5.1	Corporate records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • standardised record creation and tracking • appropriate retention and destruction of records • training for relevant staff in corporate records management.	SM	SM

Collection, use and storage of information

Action	Description	Organisation's self-rating	Surveyor Rating
14.6.1	Monitoring and analysis of clinical and non-clinical data and information occur to ensure: • accuracy, integrity and completeness • the timeliness of information and reports	SM	SM

	• that the needs of the organisation are met and improvements are made as required.		
14.6.2	The information management system is evaluated to ensure that it includes: • identification of the needs of the organisation at all levels • compliance with professional and statutory requirements for collection, storage and use of data • the validation and protection of data and information • delineation of responsibility and accountability for action on data and information • adequate resourcing for the assessment, analysis and use of data • data storage and retrieval facilitated through effective classification and indexing • contribution to external databases and registers • training of relevant staff in information and data management.	SM	SM
14.7.1	The organisation uses data from external databases and registers for: • research • development • improvement activities • education • corporate and clinical decision making • improvement of care and services.	SM	SM
14.8.1	Staff have access to contemporary reference and resource material.	SM	SM

Information and communication technology

Action	Description	Organisation's self-rating	Surveyor Rating
14.9.1	The ICT system is evaluated to ensure that it includes: • backup • security • redundancy • protection of privacy • virus detection • preventative maintenance and repair • disaster recovery / business continuity • risk and crisis management • monitoring of compliance with ICT policy and procedures.	SM	SM
14.9.2	Licences are purchased as required to ensure intellectual property rights and title to products are retained by product owners.	SM	SM

Corporate Systems and Safety

Strategic and operational planning

Action	Description	Organisation's self-rating	Surveyor Rating
15.1.1	The strategic plan that: • includes vision, mission and values • identifies priority areas for care, service delivery and facility development	SM	SM

	• considers the most efficient use of resources • includes analysis of community needs in the delivery of services • formally recognises relationships with relevant external organisations is regularly reviewed by the governing body.		
15.1.2	Leaders and managers act to promote a positive organisational culture.	SM	SM
15.1.3	Operational plans developed to achieve the organisation's goals and objectives and day-to-day activities comply with appropriate by-laws, articles of association and/or policies and procedures.	SM	SM
15.2.1	Changes driven by the strategic plan are communicated to, and evaluated in consultation with, relevant stakeholders.	SM	SM
15.2.2	Change management strategies are implemented to achieve the objectives of the strategic and operational plans.	SM	SM

Systems and delegation practices

Action	Description	Organisation's self-rating	Surveyor Rating
15.3.1	The processes of governance and the performance of the governing body are evaluated to ensure that they include: • formal orientation and ongoing education for members of the governing body • defined terms of reference, composition and procedures for meetings of the governing body • communication of information about governing body activities and decisions with relevant stakeholders • defined duties and responsibilities and a role for strategy and monitoring.	SM	SM
15.4.1	Compliance with delegations is monitored and evaluated, and improved as required.	SM	SM
15.5.1	Organisational structures and processes are reviewed to ensure that quality services are delivered.	SM	SM
15.6.1	There is evidence of evaluation and improvement of the system to govern and document decision making with ethical implications, which includes: • a nominated consultative body • a process to receive, monitor and assess issues • review of outcomes.	SM	SM
15.7.1	Organisational committees: • have access to terms of reference, membership and procedures • record and confirm minutes and actions of meetings • implement decisions and are evaluated, and improved as required.	SM	SM
15.8.1	The organisation has sound financial management processes that: • are consistent with legislative and government requirements • include budget development and review • allocate resources based on service requirements identified in strategic and operational planning • ensure that useful, timely and accurate financial reports are provided to the governing body and relevant managers • include an external audit.	SM	SM

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External Service Providers

Action	Description	Organisation's self-rating	Surveyor Rating
15.9.1	There is evidence of evaluation and improvement of systems to manage external service providers, which: • are governed by implemented policy and procedure • include documented service agreements • define dispute resolution mechanisms • monitor compliance of service providers with relevant regulatory requirements and specified standards • require evidence from service providers of internal evaluation of the services they provide • ensure that external service providers comply with organisational policy and procedures.	SM	SM
15.9.2	The organisation evaluates the performance of external service providers through agreed performance measures, including clinical outcomes and financial performance where appropriate, and improvements are made as required.	SM	SM

Research Governance

Action	Description	Organisation's self-rating	Surveyor Rating
15.10.1	The system that: • determines what research requires ethical approval • oversees the ethical conduct of organisational research • monitors the completion of required reporting is evaluated, and improved as required.	SM	SM
15.10.2	Consumers and researchers work in partnership to make decisions about research priorities, policy and practices.	SM	SM
15.11.1	Systems are implemented to effectively govern research through policy / guidelines consistent with: • jurisdictional legislation • key NHMRC statements • codes of conduct • scientific review standards.	SM	SM
15.11.2	The governance of research through: • documented accountability and responsibility • establishing formal agreements with collaborating agencies • adequately resourcing the organisation's human research ethics committee (HREC), where applicable is evaluated, and improved as required.	SM	SM

Safety management systems

Action	Description	Organisation's self-rating	Surveyor Rating
15.12.1	Safety management systems include policies and procedures for: • work health and safety (WHS) • manual handling • injury management • management of dangerous goods and hazardous substances • staff education and training in WHS responsibilities.	SM	SM

15.13.1	The system for ensuring WHS includes: • identification of risks and hazards • documented safe work practices / safety rules for all relevant procedures and tasks in both clinical and non-clinical areas • staff consultation • staff education and provision of information • an injury management program • communication of risks to consumers / patients and visitors and is implemented, evaluated, and improved as required.	SM	SM
15.13.2	Staff with formal WHS responsibilities are appropriately trained.	SM	SM
15.13.3	A register of dangerous goods and hazardous substances is maintained and Material Safety Data Sheets (MSDSs) are available to staff.	SM	SM
15.14.1	There is evidence of evaluation and improvement of the radiation safety management plan, which: • is coordinated with external authorities • includes radiation equipment, a register for all radioactive substances, and safe disposal of all radioactive waste • ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA) • keeps consumer / patient radiation to a minimum whilst maintaining good diagnostic quality • includes a personal radiation monitoring system and any relevant area monitoring.	SM	SM

Buildings, plant and equipment

Action	Description	Organisation's self-rating	Surveyor Rating
15.15.1	The procurement, management, risk reduction and maintenance system includes: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables • workplace design.	SM	SM
15.15.2	Plant and other equipment are installed and operated in accordance with manufacturer specifications, and plant logs are maintained.	SM	SM
15.16.1	Incidents and hazards associated with: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables are documented and evaluated, and action is taken to reduce risk.	SM	SM
15.16.2	The safety and accessibility of buildings / workplaces, and the safe and consistent operation of plant and equipment, are evaluated,	SM	SM

	and improvements are made to reduce risk.		
15.17.1	Access to the organisation is facilitated by: • clear internal and external signage • the use of relevant languages and multilingual / international symbols • the provision of disability access • facility design that meets legislative requirements and/or is based on recognised guidelines.	SM	SM

Emergency and disaster management

Action	Description	Organisation's self-rating	Surveyor Rating
15.18.1	There is evidence of evaluation and improvement of the emergency and disaster management systems, which include: • identification of potential internal and external emergencies and disasters • coordination with relevant external authorities • installation of an appropriate communication system • development of a response, evacuation and relocation plan • display of relevant signage and evacuation routes • planning for business continuity.	SM	SM
15.19.1	There is evidence of evaluation and improvement of staff training and competence in emergency procedures, which includes: • education at orientation • annual training in emergency, evacuation and relocation procedures • regularly conducted emergency practice / drill exercises • the appointment of an appropriately trained fire officer • access to first aid equipment and supplies, and training of relevant staff.	SM	SM
15.20.1	There is documented evidence that an authorised external provider undertakes a full fire report on the premises at least once within each EQuIPNational cycle and/or in accordance with jurisdictional legislation.	SM	SM
15.20.2	There is a documented plan to implement recommendations from the fire inspection.	SM	SM

Physical and personal security

Action	Description	Organisation's self-rating	Surveyor Rating
15.21.1	Service planning includes strategies for security management.	SM	SM
15.21.2	The organisation-wide system to identify and assess security risks, determine priorities and eliminate risks or implement controls is evaluated, and improved as required.	SM	SM
15.22.1	Staff are consulted in decision making that affects organisational and personal risk, and are informed of security risks and responsibilities.	SM	SM
15.22.2	Security management plans are coordinated with relevant external authorities.	SM	SM
15.23.1	The violence and aggression management plan is evaluated to ensure that it includes:	SM	SM

• policies / procedures for the minimisation and management of violence and aggression
• staff education and training
• appropriate response to incidents.

Waste and environmental management

Action	Description	Organisation's self-rating	Surveyor Rating
15.24.1	The waste and environmental management system is evaluated to ensure that it includes: • development and implementation of policy • coordination with external authorities • staff instruction and provision of information on their responsibilities.	SM	SM
15.25.1	Controls are implemented to manage: • identification • handling • separation and segregation of clinical, radioactive, hazardous and non-clinical waste, and the controls are evaluated, and improved as required.	SM	SM
15.26.1	The system to: • increase the efficiency of energy and water use • improve environmental sustainability • reduce carbon emissions is evaluated, and improved as required.	SM	SM

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Recommendations from Current Survey

Not applicable

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Recommendations from Previous Survey

Not applicable

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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**

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**

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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**

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**

EN OWS

Organisation: Brisbane Private Hospital
Orgcode: 720561

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**

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Organisation: Brisbane Private Hospital
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Organisation - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

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Organisation: Brisbane Private Hospital
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Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**

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Organisation: Brisbane Private Hospital
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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	36	3	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	**206**	**3**	**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**

EN OWS

Organisation: Brisbane Private Hospital
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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	38	3	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	**253**	**3**	**256**	**Met**

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Surveyor - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

EN OWS

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Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**