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

Darwin Private Hospital

Casuarina, NT

Organisation Code: 62 02 77

Survey Date: 26-28 September 2017

ACHS Accreditation Status: **ACCREDITED**

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

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Darwin Private Hospital
Orgcode : 620277

Survey Report

Survey Overview

Darwin Private Hospital (DPH) is a busy private hospital with a busy elective surgical casemix, a stable maternity service with Special Care Nursery facilities and general medical/rehabilitation services co-located with a major public tertiary healthcare provider.

The executive team's commitment to quality and safety is authentic, and with the addition of many new Nurse Unit Managers (NUMs), is actively leading the organisation to strengthen its safety and quality culture, in part in response to an unfortunate sentinel event two years ago which has had a profound effect on the hospital community. There is evidence of an organisation which increasingly understands the importance of audit and evaluation which has contributed to ongoing quality improvement across the ten National Standards and positive outcomes are noted throughout. The organisation's risk management and quality frameworks are robust and work in relation to recognition and responsiveness to the clinically deteriorating patient is particularly impressive.

Collaboration with the co-located major public hospital has also improved significantly in recent years, leading to multiple opportunities where both hospitals benefit and will benefit further in the future.

The surveyors found the organisation well prepared for survey, and were provided with a comprehensive self-assessment. Surveyors were given the opportunity to visit all clinical areas. In addition, the survey team met with DPH executives and numerous clinical and non-clinical staff. Surveyors also met with Visiting Medical Officers (VMOs) who were active members of the Medical Advisory Committee.

The surveyors were also given access to extensive policies, procedures and other relevant documents.

The surveyors noted that staff are uniformly very proud of their organisation and its growing achievements. Attracting and retaining staff has always been a major risk for the organisation given Darwin's small population, its distance from major cities, and climatic challenges, but staff are provided with, and take advantage of, numerous opportunities for education, training and professional development.

Both recommendations from previous survey have been closed. A number of suggestions for improvement have been made across all National Standards but the organisation has satisfactorily met all required actions.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

DPH is one of forty-six private hospitals owned and managed by Healthscope Pty Ltd. As a Healthscope hospital, DPH is in the fortunate position of having access to the comprehensive suite of Healthscope policies and procedures, where contemporaneity, review and monitoring is maintained.

Evidence was provided of examples of business decision making where DPH has taken patient safety and quality into consideration both in recent decisions, and in planning future new services. Such evidence was further supported by conversations with representatives from the Medical Advisory Committee (MAC) who stated that the organisation was very responsive to patient safety when considering new business ventures and that each new project's quality and safety overlay was reviewed before proceeding. To strengthen its processes, it is suggested that all projects formally include an evaluation framework by which to measure its success.

Quality and safety indicators are regularly reviewed by the DPH executive and at corporate level. Surveyors were impressed by the General Manager's knowledge and engagement in this regard.

Many examples of quality and safety activities implemented to enhance care were presented - some in response to unfortunate events which had resulted in a patient death; others at local ward level to improve specific patient experiences. Recent changes to personnel at ward leadership level have clearly invigorated staff to make multiple improvements.

Staff who spoke with surveyors were all able to articulate their responsibilities in regard to safety and quality; as were agency staff. This is an important element as the permanent workforce waxes and wanes seasonally, and reliance on agency midwives in particular is high at these times. Education is provided at orientation and throughout the year to keep staff updated to their roles.

Training opportunities are readily available and well utilised by staff. The program comprises online, face-to-face and competency-based features. Mandatory training is clearly defined and monitored and surveyors noted the concerted effort recently undertaken to ensure high levels of compliance. While results are well within acceptable range, ongoing diligence is required to maximise training results across all areas and over the entire year to avoid a 'race to the finish' in the lead up to the accreditation survey. Agency staff are well orientated to their work environment and expectations of their role. The role of resident medical officers (RMO) on rotation from Royal Darwin Hospital (RDH) has been recently reviewed and changes made to clarify and strengthen requirements. The planned employment of a part-time Director of Medical Services (DMS) will greatly facilitate implementation of these changes.

A comprehensive, integrated risk management system is in place with a corporate element monitoring enterprise risks and high/extreme local risks; together with a local level system whereby risks are annually revised and regularly reviewed via the Risk Register. While there are processes in place to monitor these local risks, surveyors suggest that as part of the annual revision, the organisation incorporates relevant risks into its annual Safety and Quality Plan for formal monitoring within the Safety and Quality framework. Notwithstanding, examples of actions taken to minimise risks and maximise safety of patient care were plentiful.

The surveyors further suggest that patients admitted to the re-named Special Observations Unit (SOU) be regularly audited against the newly developed Admission Criteria to ensure only appropriate patients are cared for in this environment; thus mitigating risks in this regard.

Clinical practice

Clinical guidelines and pathways are available and widely used; particularly the latter. Where pathways which include requirements for variance identification are in use, it was noted by surveyors that variance analysis was in general not well done and it is suggested that this be addressed to ensure system failures are identified for improvement action.

Mechanisms are in place to identify patients at increased risk of harm through a comprehensive range of assessments. Private surgeons and anaesthetists form part of this system to appropriately manage patients in the lead up to surgery, and the Pre-Admission Nurse in the Day Stay Unit (DSU) (through which all elective surgical patients are admitted) is a lynch-pin in detecting potential clinical risks prior to surgery.

Accurate, integrated patient clinical records are readily available to the clinical workforce at the point of care, and a system is in place to rapidly access records from secondary storage. Privacy is protected and records well secured to avoid inappropriate access. Antenatal records are securely stored in the Birth Suite for ready access on the arrival of a woman in labour. Patient record audits are undertaken in accordance with Healthscope policy and over the past twelve months show pleasing trends from a very low base to near 100% compliance in documentation of clinical risk assessments and observations. Surveyors observed however a number of examples where staff members' signatures were illegible and did not include a legible, printed name/ designation. The challenge for the organisation is to maintain its most recent positive results in regard to documentation and surveyors suggest continued attention to audit until it is satisfied that cultural change in this regard is embedded. This includes audit of observations in the Special Observations Unit.

Performance and skills management

The scope of practice for the clinical workforce, including VMOs is well defined and regularly viewed. Monitoring mechanisms are rigorous to ensure clinicians work within their agreed scope, including when a new service, procedure or technology is introduced. Relevant supervision is provided and examples given where new/junior surgeons were required to work under the supervision of more senior/experienced surgeons until credentials were established and competency ascertained.

Performance review using a validated, reliable tool is in place and results of audit indicated that 96% of staff had undergone a performance review in the last twelve months, many in the most recent quarter.

Evidence was provided of all staff having access to, and attending, ongoing training in safety and quality as part of their professional development. Opportunities are provided for staff to provide feedback in this regard, and findings are analysed to inform continuous improvement. Many examples of actions taken to increase staff understanding of the organisation's safety and quality systems were provided.

Incident and complaints management

In regard to incident management, a positive reporting culture is noted, and there is vigorous analysis and review of all incidents. Action plans are developed in response to incidents where required and monitored by the relevant committee or individual senior manager. The General Manager actively participates in the incident review and analysis process and links to the organisation's risk management program are well established. Staff and VMOs are kept abreast of review outcomes. Additionally, the Healthscope Shared Learnings program is an excellent vehicle for hospitals under the company's umbrella to mitigate their own risks learning from the experiences of other hospitals with a similar casemix where an incident has occurred.

Similar systems exist for complaints recognition and response; with managers encouraged to address feedback quickly at local level. All patient feedback, whether positive or negative is readily available at ward level and to the Medical Advisory Committee via the Executive team, and formal processes are in place to ensure it reaches the Healthscope Corporate Executive. Such feedback is used to improve the patient experience and enhance services provided by the organisation.

An Open Disclosure Program is in place and all staff are trained to the appropriate level for their role and function within the organisation.

Patient rights and engagement

The Charter of Patient Rights, which is consistent with the National Charter is provided to every patient and on display, in easily understood plain language, throughout the hospital. Systems are in place to support patients who may not fully understand their rights, including the use of interpreters as required. Patients and carers participate in planning their treatment via clinical handover, dialogue with their doctor and at family case meetings for complex rehabilitation/elderly patients. Journey boards were in use throughout the facility for ease of communication.

Informed consent, including financial consent, was noted to be meticulous across the board. Mechanisms to support the documentation of Advance Care Directives are in place and treatment limiting orders, via the Medical Orders Life Sustaining Treatment (MOLST) Chart were evident.

NSQHSS Survey

Organisation : Darwin Private Hospital
Orgcode : 620277

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

Organisation : Darwin Private Hospital
Orgcode : 620277

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Consumer representation has been reinvigorated in the past six months, and the small group of consumers report to the Quality Manager. Consumers are provided with a consumer representative training package to assist with their orientation, as well as having the same orientation as the rest of the staff. Consumers provide representation on the Quality and Infection Control Committee, and it is suggested that these representatives are briefed on the meeting papers prior to the meeting, so that there is a greater opportunity for them to provide input.

Consumer partnership in designing care

Surveyors noted the positive initiative of having consumers contribute to staff orientation. It would be useful to assess the value of the consumer input to this process. Consumers were also involved in the recent design of the escalation of care procedures information.

Consumer partnership in service measurement and evaluation

Consumer representatives have commenced patient surveys, meeting one-on-one with the patients. The survey is designed to ascertain patients' perception of their care and their involvement in their care. It is suggested that some of the questions on the survey tool be revised to increase the understanding of the questions by the representative and patients.

All new brochures and information for hospital patients are reviewed by a consumer representative prior to publication, to ensure that the information is presented in a consumer-friendly manner. This initiative is flagged by a logo on the brochure. Surveys are also emailed to patients on discharge, and feedback is provided to the ward managers.

NSQHSS Survey

Organisation : Darwin Private Hospital
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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

Organisation : Darwin Private Hospital
Orgcode : 620277

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Governance and management systems for healthcare associated infections (HAIs) are well supported by relevant Healthscope, HICMR and local policies. The HICMR policies utilised within DPH appear to be mainly the Environmental Services, CSSD and Endoscopy policies which are easily accessed through the HICMR Client Portal on all computers. The HICMR contract includes a facility wide risk assessment every two years. At the time of survey, the results of the 2017 risk assessment undertaken two weeks prior to survey were not immediately available however were able to be accessed before the last day of survey. The 2015 risk assessment across all units of DPH had an overall compliance of 91%; 329 recommendations of which 228 had been implemented. The 2017 risk assessment has addressed the outstanding recommendation from the previous report with an overall rating of 96% received for the Facility Wide assessment. The survey team acknowledges that HICMR biannual Risk Assessment in relevant areas within DPH provides the opportunity to identify opportunities for improvement. More recently these risk assessments have been adjusted to include the required Gap Analysis for the AS/NZS 4187: 2014 which the hospital has used to develop a very detailed Implementation Plan to address identified gaps in compliance. Accordingly, it is suggested that processes of review and evaluation of outcomes achieved against the HICMR recommendations be strengthened by more frequent reviews. Contemporaneous documentation of the evaluation of achieved outcomes will be important evidence for the next survey and the required annual evaluation of the Infection Control program and Committee effectiveness.

An Infection Control Coordinator (ICC) is responsible for supporting and implementing systems and processes of the infection control system. A full-time position is divided between Quality and Infection Prevention and Control, thus the combined Quality and Infection Prevention Committee. The current infection prevention and control plan is endorsed and regularly reviewed by the Infection Prevention and Quality Committee and DPH Executive.

The surveillance system of HAIs is well established to provide data as required for ACHS indicators and Healthscope KPIs.

The effectiveness of the Infection Prevention and Control (IPC) system is regularly reviewed by the DPH Infection Prevention and Quality Committee and DPH Executive.

Infection prevention and control strategies

Hand Hygiene (HH) audit results indicate continual improvement since the last survey. Overall result for 2016 was 80.5% and the YTD 2017 hospital wide result is 85.7% which is above the Healthscope benchmark and national average. Managers and staff continue to promote opportunities for continual improvement to ensure compliance by all occupational groups. Hand gel and hand washing sinks are appropriately located throughout all clinical areas.

A Healthscope workforce immunisation program consistent with the current national guideline is in place however DPH staff compliance is relative low at 63%. Uptake across the hospital for the flu vaccination was only 47% this year. Whilst there is an existing action plan in place to address the low staff compliance with vaccination requirements it is suggested that this action plan could be strengthened with more specific strategies to address non-compliance in all CAT A staff to ensure compliance with Healthscope Policy 4.26. It was pleasing to note that 100% of staff in the Maternity unit demonstrated evidence of Pertussis vaccination, given that is a very risk area for newborn babies.

Staff compliance with Personal Protective Equipment (PPE**)** along with all other relevant areas of occupational health and safety procedures and protocols is monitored and corrective action taken to improve compliance.

Similarly, the organisation's management of invasive devices is closely monitored according to Healthscope policy. This monitoring links with specific education and competency assessment of aseptic technique. Staff compliance with ANNT annual competency training and assessment at the time of survey is 98%.

Staff meetings and noticeboards are used to promote strategic work health and safety infection prevention messages, results of audits and introduction of new products and procedures.

Managing patients with infections or colonisations

A manual surveillance program is in place for the early detection and management of infections and colonisation. This program relies on the ICC to review all pathology results that are faxed into the department. It is also reliant on the patient self-declaration of their infectious status in the pre-admission documentation and the scrutiny of infectious/colonisation status of patients being transferred into DPH. Once identified and or admitted the patient's infectious status is available in the Webpas electronic system.

Monthly HAIs are recorded in RiskMan and discussed at the Infection Prevention and Quality Committee, Patient Care Committee and MAC. The HAI rate whilst relatively low still indicates room for improvement.

Guidelines for standard precautions and transmission based precautions are readily available for clinical and non-clinical staff as required. Transmission based precautions are utilised as required. The Webpas electronic system is available in all clinical units and on cleaners iPads, to identify patient's requiring transmission based precautions.

Monitoring of standard and transmission based precautions is undertaken. This monitoring however is restricted to annual equipment audits, the results of which are regularly 100%. CNC and NUM involvement in overseeing the implementation of standard and transmission based precautions appears to occur however there is no data to demonstrate staff compliance with practice.

Accordingly, it is suggested that more frequent 'just in time' observational audits be undertaken and recorded when transmission based precautions are actually being used to complement the current annual audit of staff knowledge and awareness of these process. In addition, it is suggested that these ad hoc observational audits of staff compliance with standard based precautions be undertaken more regularly, documented and used to enhance staff compliance with best practice.

Antimicrobial stewardship

An AMS stewardship program is in place, supported by Healthscope policies. A new ID physician has joined the multidisciplinary team, and the new provider of pharmacy services will play a part in the program. AMS is a standing item at the IPC and Quality, Medication Safety Committee and PCRC committee meetings. The antimicrobial stewardship stoplight chart has been developed to assist with prescribing and review of antibiotic usage.

The clinical workforce has access to current endorsed guidelines on antibiotics usage through computer access and/or hard copy access to Therapeutic Guidelines: Antibiotic; and adult surgical prophylaxis guidelines are displayed in poster form in the theatre complex.

Monitoring of antimicrobial usage is undertaken, and when the new pharmacy provider is established, they are scheduled to submit a NAPS baseline audit and action plans to ensure ongoing compliance with the guidelines developed.

The surveyors encourage the organisation to strengthen the existing program by continue reviewing antibiotic usage in accordance with the guidelines.

Cleaning, disinfection and sterilisation

Policies and procedures for environmental services are available to ensure the principles of infection prevention and control are practiced in cleaning, waste management, and linen transportation, and storage. Clinical cleaning schedules as well as environmental cleaning schedules are well established. The HICMR Facility Wide Environmental audit in 2015, 2016 and 2017 indicate 97%, 96% and 96% compliance. There is an identified need to resolve the issue of hospital purchased standard required coloured mops not being returned from the external laundry. The surveyors note that this issue has been raised as a HICMR recommendation. A clinical waste and linen management audit for the last three years demonstrates greater than 90% compliance. Current material data sheet are readily available to staff.

The surveyors sighted evidence of monitoring of Air Handling Systems, Legionella Detection in Water Systems, and monitoring of the water quality of the Hydrotherapy pool, Cooling Towers, Steam Sterilisers and disinfection machines including Endoscopy Steris machines.

A Gap Analysis to determine the current level of compliance with AS/NZS 4187:2014 was undertaken recently by HIMR as part of the regular biannual risk assessments. A significant number of areas of non-compliance have been identified and are now included in a detailed Implementation Plan to address all identified gaps including recommendations from the 2017 HIMR risk assessment audits.

Evidence of many of these gaps was clearly visible during survey including the inappropriate dirty to clean flow pathway for used scopes in the Endoscopy cleaning and processing room. Evidence of a scheduled redesign of this area to correct the flow of cleaning and reprocessing and storage of scopes has been scheduled and approved to be undertaken in January 2017. The surveyors were informed that other identified redesign work in CSSD is to be undertaken at this same time and includes some of the recommendations identified in the current Implementation plan.

A manual tracking system is used in CSSD and Endoscopy Reprocessing both of which are tested back to patients 6 monthly in addition to the required annual Healthscope Traceability audit.

CSSD staff are required to have a Certificate III in sterilisation or working towards same. Endoscopy cleaning and reprocessing are trained through HICM however there is a current plan to commence GENCA training and required competency assessment now that the Educator is a member of GENCA and undertaking relevant training to become an assessor.

The surveyors were informed that clean Utility areas of the hospital are scheduled to be updated in the near future which will provide the opportunity to ensure sterile stock is maintained in accordance with AS/NZS 4187:2014 in these ward areas. Sterile stock storage areas in the operating theatre are required to be temperature monitored and alarmed. There is one identified storage area within the operating theatre suite that is not functioning appropriate and which the surveyors were informed would be addressed in the Christmas/New Year downturn in activity. During the survey, there was an identified inappropriate storage of sterile stock outside theatre 7 required for the days cases as well as inappropriate linen storage in theatre and ward areas. Both issues were corrected during survey. Closer monitoring of these areas of recent non-compliance is encouraged.

The surveyors were impressed with the process of cleaning staff being able to access their work schedules through the WebPas system using their allocated IPADs. This provides the staff with up-to-date information about the commencement or cessation of transmission based precautions, new admissions and their infectious status and all discharged patients.

Communicating with patients and carers

The “MyHealthscope” website provides public access to DPH Clinical Outcome performance for infection rates and hand hygiene compliance rates of staff and doctors. Appropriate brochures are available for patients and families on the management and reduction of healthcare associated infections. Appropriate signage in lifts, corridors and public places prompts visitors to wash their hands and use appropriate cough etiquette. Hand hygiene stations are strategically positioned. Patient and consumer feedback on the usefulness of provided information is sought and used for improvement.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

Evidence was sighted that 98% of relevant staff have undertaken ANTT Education and undergone ANTT Competency assessment. Accordingly, this (transitional) action is fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

A Gap Analysis has been undertaken, the results of which were sighted during survey. An implementation plan has been developed in the form of a Gant spread sheet to list all the gaps identified and the timeline for implementation. Accordingly, this action is rated SM with a suggestion to ensure that the identified actions included in the implementation plan are completed in the anticipated time schedule.

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 : Darwin Private Hospital
Orgcode : 620277

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Comprehensive medication safety systems are established at DPH guided by Healthscope corporate policies and procedures These policies are readily available for staff to access, and a laminated IT card is located on DPH computers, providing access information for DPH and Healthscope policies.

The DPH Medication Safety Committee, which is responsible for overseeing drug and therapeutic activities meets regularly, and reports are provided to the MAC and the hospital executive. DPH also reports its outcomes to the company's highest level of governance via the Healthscope Quality KPI dashboard.

The DPH safety and quality plan includes medication safety and DPH submits ACHS medication safety indicators. The Risk Register on the RiskMan system includes medication management, and reports from this are regularly reviewed. In addition, Healthscope corporate has a Medication Safety Cluster which meets quarterly and develops group-wide policy and guidelines, monitors audit outcomes and reviews serious medication incidents.

A new pharmacy provider commenced at DPH on 1 September 2017, and staff almost immediately reported an improvement in pharmacy service provision. A pharmacist is now on site during business hours Monday to Friday.

DPH nursing staff have access to eLearning Med Safe training, and managers are provided with compliance reports which are then discussed with staff.

The Medication Safety Self-Assessment audit was performed in 2016, and the National Inpatient Medication Chart (NIMC) audit has also been conducted. Whilst the NIMC is used throughout the adult patient population, it is suggested that consideration be given to the use of the paediatric NIMC for all paediatric patients, which may necessitate extending its use to RDH to ensure consistency.

When reporting results, it is suggested that the graphs produced provide data with adequate information, such as the inclusion of the sample size. Illegible signatures and illegible medication orders have also been identified as a risk, and it is suggested that there be increased education about this.

A Venous Thrombosis Embolism (VTE) risk assessment form is used, and it is suggested that education be provided re increasing the transfer of this information to the NIMC.

The surveyors note plans are well underway to renovate the medication rooms in some ward areas which will provide a safer medication preparation environment as there will then be limited access to the medication preparation and storage areas.

Documentation of patient information

DPH assesses all in-patients for medication safety using the Healthscope Risk Assessment form. For scores greater than four, the pharmacist is sent a referral form, and a best possible medication history (BPMH) is documented on the Medication Management Plan (MMP). For lower scores, the nurse signs off against the medication information provided by the patient at admission. It is suggested that this information or the MMP be available at the point of care to assist the process of medication reconciliation.

A referral for pharmacist review can also be generated by clinical staff, and the pharmacist will also complete a BPMH for these patients.

Surveyors noted some inconsistencies amongst staff in reviewing medication orders against their medication history and prescribers plan and reconciling any discrepancies. It is suggested that pharmacists, nursing and medical staff are provided with additional education about medication reconciliation to ensure this occurs comprehensively.

DPH has an Alert sheet at the front of the patient medical record. However, on some sheets it was noted that there was no documentation of allergies and surveyors suggest that the organisation educates staff on the importance of ensuring this occurs.

A system is in place to identify and document adverse drug reactions, and to report these to the Therapeutic Goods Administration.

Medication management processes

Current medicines information is available on computers, and signage provides information on how to access this. Hard copy reference books were the current editions. However, it is suggested that there be a computer terminal in each medication room to ensure that the most up-to-date information is always available. Additionally, The Australian Medicines Handbook is a resource that could be utilised more by staff.

Since the change in pharmacy providers, medications are provided from an off-site community pharmacy until the planned refurbishment of an on-site pharmacy. Four deliveries a day are made from the community pharmacy at times which are well publicised, and imprest stock is provided from a warehouse.

Monitored medication refrigerators are used, and there is a procedure for notifications when there is a potential cold chain breach. TallMan lettering is on some products in the medication room and there is a plan to increase the number of TallMan product labels. Oral dispensers were available for use for liquid medications.

It was observed that not all the medication charts viewed had complete information about patients' allergies and staff should be educated to improve compliance with this within the audit framework. Disposal of unwanted medicines is undertaken by the community pharmacy provider.

High risk medicines area clearly identified with lists on the medication cupboards; and only potassium in premix bags was available in wards.

Continuity of medication management

Continuity of medication management occurs at management from admission through to discharge. Changes in medications are passed on to oncoming clinical staff at clinical handover. Reconciling medicines when care is transferred, and especially at discharge, is important. The pharmacist provides a medication list for high risk patients at discharge and discusses this with patients and/or carers.

Communicating with patients and carers

The pharmacist is available to provide education to patients, and staff have access to CMI using MIMs online to assist patients as required. There being limited evidence of a consumer medication management plan being used consistently, surveyors suggest that this be considered for appropriate patients to assist with their medication management post-discharge.

Information provided has been reviewed by consumers and found to be easily understood and meaningful.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Darwin Private Hospital
Orgcode : 620277

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

There are clear well-established systems and process in place to identify patients at key points of their continuum of care to ensure compliance with relevant Healthscope policies. WebPAS Patient Information System linkage to the Zebra printer enables patient arm bands to be printed with the Healthscope approved four patient identifiers in all clinical areas. The DPH policy is that one only white band is used to identify an adult patient and an admitted child is provided two armbands (arm and leg generally) and parent/ parents have the child's armband attached to their arm. In maternity babies armbands are identified 'baby of (mothers full name)'. A range of audits are in place to monitor staff compliance with trend audit data being reported to the Patient Care Review committee indicating generally good compliance.

Recently one near miss reported incident has resulted in a change in the process of identification for Expressed Breast Milk (EBM). This change ensures the EBM is labelled by the mother herself, using the mothers Identification label. Since this quality improvement and change in practice there has been no reported incidents to date which is very positive.

The surveyors observed the surgical patient's journey from arrival at reception where the patient completed pre-admission information was checked with the patient and the patient identification label was then produced by the Zebra Printer using the patient's full name, date of birth, gender and UR number. This armband was clipped to the patient file and the patient directed to the Day Surgery admission area located on the first-floor clerical admission area where the patient information was taken, leaving the patient to wait in an unattended lounge until the RN admission process was undertaken. It is at this last point the patient's identification armband is attached to the patient. Staff were not able to clarify the average patient waiting time in the lounge area except to say depending on the day it could be anything from ten minutes to a couple of hours.

Accordingly, a suggestion is made to review and risk assess the current admission process of the patient admission for elective surgery where the identification arm band is not applied until the patient is admitted in the pre-admission interview room.

Processes to transfer care

Surveyors observed meticulous adherence to policy of patient identification at bedside clinical handover, transfer into and through the various stages within the operating theatre and into recovery then back to the ward. The same process is required when patients transfer to medical imaging and the gym.

Similar processes are in place to manage patient transfer between the DPH and the RDH which appears to be a very frequent occurrence.

Processes to match patients and their care

Audit data sighted indicated 100% compliance with Healthscope policies for patient identification and procedure matching. A Surgical Safety Checklist modelled on best practice is used in both the operating theatre and the Angiography Suite. The surveyors had the opportunity to witness team time out being undertaken by the entire medical, nursing and technical team during the survey.

Site marking by the surgeon was also evident in observed processes to match patients and their care during the survey.

NSQHSS Survey

Organisation : Darwin Private Hospital
Orgcode : 620277

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation : Darwin Private Hospital
Orgcode : 620277

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Healthscope policies, procedures and protocols provide the framework for arrange of clinical handover situations in DPH. Each has a specific form incorporating the principals of ISOBAR to be used during the handover. Every clinical handover situation requires patient and/or carer verbal confirmation of their full name, unique identification number and date of birth against the patients printed Identification Band. Evaluation of compliance with clinical handover policy includes scheduled observational audits and audit outcome review by the Infection Prevention and Quality Committee.

All clinical handover incidents and near misses are required to be reported in RiskMan and reported to the Executive, Healthscope as a KPI and discussed at the Infection Prevention and Quality Committee and the Patient Care Review Committee.

Risks associated with clinical handover are recorded in the risk register.

Clinical handover processes

Clinical Handover is practiced in a multitude of situations such as ward shift change, inter hospital transfers including to radiology, operating theatre and recovery as well as between RMOs and medical teams both within DPH and RDH. Surveyors observed Patient Bedside Clinical Handover between shifts and the various stages of the perioperative and postoperative surgical and angiography suite patient journeys. Compliance with policy and related procedures including patient engagement was clearly evident on all occasions.

A WHO Surgical Safety Checklist incorporates the process of Team Time Out. This process was observed on a number of occasions during survey to be a well-established process that is undertaken with the full team and patient involvement.

Patient and carer involvement in clinical handover

In the majority of these process the patient and/or carer is involved in the process. Patient feedback indicates high satisfaction with being involved in the clinical bedside handover in ward shift changes. A number of patients spoken with during the survey confirmed this high level of satisfaction of involvement. Patients also commented favourably to surveyors about the process of purposeful rounding by staff that has recently been introduced in DPH.

NSQHSS Survey

Organisation : Darwin Private Hospital
Orgcode : 620277

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 : Darwin Private Hospital
Orgcode : 620277

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Both Healthscope and relevant local DPH policies, that are referenced appropriately to national evidence-based guidelines, provide the governance framework for safe and appropriate prescription, administration and management of blood and blood products. The local DPH Blood Management Committee meets quarterly. Membership includes representatives from the on-site pathology company and the Royal Darwin Hospital Transfusion Committee, VMO and key nursing personal. The chair of the DPH Blood Service Committee is a member of the Northern Territory Transfusion Committee and the Healthscope Corporate Transfusion Committee. The RiskMan incident reporting system is used to report any incident associated with blood and blood product prescription, administration or management. Identified risks are appropriately added to the risk register and reviewed and actioned through relevant committees.

Haemovigilance is overseen by both the ACL Pathology blood management service and the DPH Blood Management Committee. Appropriate systems are in place to capture and review adverse transfusion reactions and non-compliance. ACL retains the responsibility and accountability for the blood fridge that serves DPH. At times depending on VMO prescription blood will need to be accessed from the RDH blood fridge. Non-clinical staff responsible for transporting blood from either the RDH or ACL Blood Fridge are required to have undertaken the Blood Safe eLearning module on cold storage.

The number of blood transfusions ranges from 30-40 per year with at least a quarter of these being for post-partum haemorrhage (PPH). Clinical appropriateness (STIR) audits indicate prescription of blood and blood products prescriptions are largely compliant with national guidelines. High blood wastage rate remains an issue largely due to circumstances beyond the organisation's control to preclude re-assignment of blood. Nevertheless, it is pleasing to note that since the last survey there has been a 16.8% waste reduction achieved through an increase in group and hold blood prescriptions for at risk maternity and elective surgical patients instead of prescriptions for cross matched blood that, if not used, cannot be returned to the blood service. In addition, there has been a decision to reduce the number of O negative blood being held in the ACL Blood Fridge from four units to two units. Both initiatives have contributed to the reduction in wastage.

All clinical staff are required to complete Blood Safe training and competency assessment. At the time of survey 100& of relevant staff had completed the annual training and competency assessment. Educational opportunities for VMOs regarding blood and blood products are available and promoted through MAC and craft group meetings.

The Healthscope Quarterly Shared Learnings report is used to reflect on potential incidents and near misses in local practice.

Documenting patient information

A best possible patient history of blood product usage is taken as part of the admission of all patients to DPH. A Healthscope comprehensive annual documentation audit is used to identify potential areas for improvement. This audit includes a number of blood and blood product associated criteria, the results of which in recent years have been the impetus to the revision of the contents contained in the Transfusion Documentation Pack to ensure consistence across all clinical areas and development of a local policy for the collection of ACL in and out of hours.

A documentation audit is completed following every episode of transfusion with results tabled and discussed at the Blood Management Committee. This audit reviews every aspect of the patients care throughout the transfusion. Feedback from this committee is provided to clinical staff meetings and to VMOs through the Theatre Users Committee, Patient Care Review and MAC.

Documentation associated with the storage and administration of anti D in the Maternity unit was sighted during survey to be comprehensive and compliant with legislation.

Managing blood and blood product safety

Systems and processes for managing blood and blood products include the receipt, storage, transportation and monitoring wastage are all regularly audited, results reviewed by the relevant committee and reported to Executive, Healthscope, Patient Clinical Review and MAC. Audits undertaken by ACL Pathology are provided to DPH and have been 100% since the last survey.

Communicating with patients and carers

Patient information relating to blood and blood products, including risks, benefits and alternative treatments largely consists of the NHMRC and Red Cross Blood Service Patient brochures. These information guides are contained in the blood transfusion packs located in all clinical units. The informed consent process is regularly audit every three months with varying results including 2016 October to December 90%; 2017 January to March 88% and 2017 April to June 93% indicating opportunities for improvement.

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

A comprehensive pressure injury prevention and management system is in place at DPH with support from Healthscope Corporate via the key Pressure Injury, Prevention and Management Policy. This policy, and those which link to it to provide additional guidance, are regularly reviewed against best available practice, and include screening and assessment tools for use at local level**.**

Monitoring of use of the suite of policies occurs via audit of documentation (completion of screening and assessment tools); review of the incident management system (RiskMan) where all pressure injuries are reported, and via Pressure Injury Prevalence (PIP) Audits where results are benchmarked across all Healthscope sites via the Corporate Quality KPI process and reported to the organisation's highest level of governance. A Healthscope-wide Corporate Pressure Injury working Cluster oversights all activity relating to prevention and management of pressure injury.

At DPH pressure injury data, collected from RiskMan, and from the prevalence surveys is reviewed in a number of forums at ward, nursing management, quality and safety, and executive level. A range of quality improvement activities undertaken to prevent/better manage pressure injuries were noted by surveyors.

Pressure injury prevention equipment and devices are readily available via the Pressure Relieving Devices List and their use observed during survey. There is currently sufficient equipment in good condition, and appropriate systems in place, to ensure that patients at risk of pressure injury are appropriately managed in a timely manner by nursing staff educated in the use of such equipment.

Preventing pressure injuries

The Healthscope policy - Pressure Injury, Prevention and Management Policy of, defines the risk screening and assessment tools in use at DPH. A modified Waterlow tool is used to assess all patients admitted to the hospital. Patients who score high on the scale have specific injury prevention plans in place.

All 'at risk' patients are re-assessed daily with nurses undertaking and documenting comprehensive skin assessments. Outcomes of assessment are documented as part of the nursing care plan and are therefore readily available to staff; further, findings are handed over to oncoming staff at clinical handover, with prompts being included on the handover tool.

Purposeful rounding which incorporates pressure injury prevention strategy, is undertaken at regular intervals.

Data on screening and assessment numbers are collected, analysed and included in the Healthscope Quality KPI dashboard – DPH has recently outperformed its peers in this regard.

Whilst surveyors similarly observed high levels of documentation accuracy and assessment completion during survey, including the Maternity service which is often an area of low compliance, surveyors found lower levels of understanding of pressure injury prevention among individual junior staff and it is suggested that the organisation takes steps to ensure all staff are suitably educated in this area to avoid placing patients at unnecessary risk.

Managing pressure injuries

Current, evidence-based wound management is in place with an expert wound management nurse providing advice on management in each instance where a pressure injury is identified, whether on the rare occasion one occurs whilst a patient is in hospital, or more likely, community acquired.

All wound management plans are regularly reviewed for compliance with policy and effectiveness of applied strategies.

Management plans for identified pressure injuries are customised to the needs of individual patients and include input from nursing staff wound management experience.

Communicating with patients and carers

Information on pressure injury prevention and management is provided to all patients and was evident during survey. Nurses discuss prevention and management with individual patients at risk of pressure injury.

Patients and carers are involved in planning pressure injury management.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

DPH has undertaken a considerable body of work in the last year to build on its existing recognition and response systems as an outcome related to a sentinel event (unplanned patient death), which had a profound effect on the entire organisation.

The overarching Healthscope Policy, Clinical Deterioration - Recognising and Responding to - is very comprehensive and outlines expectations and accountabilities at local hospital level. Numerous other supportive corporate policies are in place. Clinical deterioration is regularly monitored and benchmarked at corporate level through a key performance indicator. A 'Shared Learnings' newsletter is produced regularly whereby all relevant hospitals review their own processes against system failures in other Healthscope hospitals, therefore reducing their own risk of such events.

Governance at DPH is currently rigorous, with a systematic approach. All relevant policies and procedures have been reviewed and revised as necessary; changes have been made to the role and function of the Resident Medical Officers (RMO) who are on rotation from the RDH; and the High Dependency Unit (HDU) has been renamed and repurposed as the Special Observations Unit (SOU), with strictly defined admission criteria. Track and trigger charting has been aligned with that of RDHs for consistency of documentation between both organisations, which frequently share staff.

A recently formed Deteriorating Patient Committee has carriage of implementing and reviewing recognition and response processes under the governance of the Patient Care Review and Medical Advisory Committees, and will contribute further improvements and enhanced monitoring as it becomes more established. The clinical workforce has been widely consulted on and contributed to all recent initiatives. Excellent feedback mechanisms are in place to keep staff engaged in the process.

All deaths and cardiac arrests appropriately reviewed including against failure of the recognition and response system. Incidents related to unexpected clinical deterioration are entered into the organisation's incident reporting system where they are monitored and reported to the various oversighting committees. Clinical staff and Visiting Medical Officers (VMOs) are kept informed of relevant data through newsletters, personal email, ward meetings and the Safety and Quality Committee.

End-of-life care, including the use of the MOLST form and Advance Care Directives, is enshrined in policy and procedure.

Recognising clinical deterioration and escalating care

Comprehensive track and trigger charting based on human factors principles is in place for all patients, with specific documentation available for neonates, paediatric patients, and consumers of maternity services. All such standard observation charts comply with the requirements of this Standard and audit outcomes from a comprehensive audit schedule demonstrate consistently high compliance with documentation of observations, with escalation to a higher level of care, and with response protocols over several months.

Care escalation processes and mechanisms to call for emergency assistance are thorough. The three tiered mechanisms – Clinical Review; Rapid Response and Code Blue are now clear and unambiguous; both theory and action were observed on several occasions by surveyors throughout their stay.

Surveyors noted the use of the Clinical Review sticker in the patient record to formally record that such a review has taken place as an excellent initiative.

Enhanced relationships with RDH have also contributed to improved patient outcomes as DPH now participates in the former's Code Blue system whereby resuscitation experts can rapidly attend private patients in the co-located hospital.

Shared reviews of the effectiveness of this system, including all Code Blue calls, now take place on a regular basis.

All clinical staff were conversant with the system in place to recognise and respond to clinical deterioration, and were able to accurately and comprehensively articulate their roles and responsibilities.

Responding to clinical deterioration

As stated three clear response mechanisms are now in place, monitored and improved through action plan as required. Criteria for triggering a call for emergency assistance are included in policies, procedures and in relevant clinical documentation.

Every call for emergency assistance is now entered into the electronic incident management system for data collection purposes, review and action where warranted.

Surveyors were very pleased to see that basic life support (BLS) training and competency rates were almost 100%. Specific expertise in neonatal and paediatric life support was similarly high amongst relevant staff and it was pleasing to see paediatricians active and enthusiastic in ensuring competency amongst nursing and midwifery staff this regard.

Many senior nursing staff are also qualified in Advanced Life Support (ALS) and while the organisation can almost guarantee an appropriately trained practitioner on every shift, and support is readily available from the major co-located public hospital, surveyors suggest that the shift by shift identification of appropriately trained staff be formalised to ensure this occurs on each and every occasion.

Communicating with patients and carers

The organisation has made a concerted effort to address the developmental actions which comprise this criterion. It was evident to surveyors that patients and their carers are encouraged to seek assistance from staff via clear Patient and Carer Escalation signage at the bedside and throughout the organisation.

Every patient and their family are provided with written information, in simple language, on how to initiate urgent assistance. At each clinical handover, patients (and/or their carers where relevant) are asked how they are feeling and whether they have noticed any changes in their condition. Data is collected for monitoring purposes in this regard.

A system is in place for preparing and receiving advance care directives with patient/family involvement. Treatment limiting orders, including the MOLST chart are in use. Such directives and orders are filed in the patient clinical record, and documented on the Alert Form, which is the uppermost form in the nursing care folder at the bedside.

A comprehensive review process is in place to ensure current processes to escalate care from the patient/family perspective meet consumer needs.

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:

Evidence sighted that 100% clinical staff are trained and proficient in basic life support, including where relevant in neonatal and paediatric BLS, thereby fully meeting the requirements of this action.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Comprehensive policies and procedures, consistent with best practice guidelines, are in place at DPH under the Healthscope corporate umbrella and its overarching policy – Falls Prevention and Management – Patient, and additional, supporting policies.

The Healthscope Falls Prevention Cluster oversights all prevention and management strategies, and includes monitoring of falls incidents across all hospitals. A corporate Quality KPI dashboard is in place to report outcomes to the highest level of governance in the organisation and to benchmark peer hospitals. Findings from reviews where injury from falls has occurred are provided to all hospitals within Healthscope via the excellent Shared Learnings Report, which allows individual hospitals to implement risk reduction strategies and avoid incidents as a result of learning from their less fortunate peers.

At local level, a comprehensive falls prevention framework is in place. A whole of organisation approach was noted by surveyors and the multidisciplinary nature of the system, where patients at risk are identified early and individualised falls prevention plans created has seen both the number of falls reduce, and injuries from falls significantly fall.

In addition, two ‘Falls Champions’ work at ward level to maintain awareness amongst staff and monitor adherence to policy.

Solid investment has been made in equipment and devices to both reduce the number of falls, and the harm caused by falls. Environmental scans have been undertaken leading to modifications in the locale and the maintenance team has contributed added value by reviewing lighting, entrances and exits.

Screening and assessing risks of falls and harm from falling

Thorough screening and assessment of falls risk processes were evident. The patient assessment form includes a validated falls risk assessment tool (FRAT). Audits are undertaken for compliance with completion, which has been improving regularly to show near 100% completion on admission.

There is a strong awareness of risk from falls in the Special Care Nursery, the Paediatric Ward and the Maternity Unit, as observed through high levels of compliance with completion of falls assessment documentation, which was pleasing to see as these areas are sometimes neglected in favour of wards where older, frailer patients reside.

Preventing falls and harm from falling

Patients at high risk of falling have falls prevention/harm minimisation plans in place. Quality improvement activities are much in evidence and numerous falls reduction strategies were noted to be in place. Purposeful rounding occurs; sensor pads are in use. Patients/families receive High Risk Falls packs, which include information and non-slip socks. April Falls Day annually draws attention to the risks associated with falls.

In the Rehabilitation Ward, patients' individual needs in regard to falls prevention are discussed at the weekly case conferences with the multidisciplinary team to maximise patient safety post-discharge.

All patients identified as a falls risk have comprehensive falls prevention plans documented in their records. The effectiveness of these plans is audited and review of incidents conducted via the incident management system. Discharge planning specifically communicates falls risk when dealing with other healthcare providers.

Communicating with patients and carers

All patients receive an information brochure on falls prevention and harm minimisation and posters are displayed throughout the organisation. Patients and carers (where required) are involved in falls prevention planning where the various strategies and options are discussed.

The organisation appears very well aware of the risk of falls to its patients. A large amount of information, in plain language is available; the content of which has been reviewed by consumer representatives to ensure it meets the needs of the organisation's clientele. Where a specific falls risk is identified, a prevention management plan is agreed between the organisation and the patient or their significant others.

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 : Darwin Private Hospital
Orgcode : 620277

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Darwin Private Hospital
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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	SM	SM

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

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

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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Documentation of patient information

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

Medication management processes

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

Continuity of medication management

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

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

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

Documenting patient information

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

Managing blood and blood product safety

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

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Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

NSQHSS Survey

Organisation : Darwin Private Hospital
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Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

NSQHSS Survey

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Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

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Recommendations from Current Survey

Not applicable.

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Recommendations from Previous Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.1 The clinical workforce is trained in aseptic technique

Recommendation: NSQHSS Survey 1014.3.10.1

Recommendation:

Continue to offer aseptic technique training for all relevant staff until full compliance is achieved.

Action:

The education system was introduced mid-2016 and all education was transferred across. There was a delay in compliance during this time. Compliance is currently at 94% online and 92% for practical assessments as at 5 September 2017.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

Almost 100% of relevant clinical staff have completed the ANTT education and undertaken ANTT competency assessment.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 1014.4.14.1

Recommendation:

Ensure that an agreed consumer medication management (action) plan is documented and provided for identified patients on discharge.

Action:

A medication risk assessment is completed for all patients. From this assessment, high risk patients have a Medication Management plan developed. These patients are also provided with a medication profile on discharge.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

The recommendation for this action has been achieved as an agreed medication action plan is now provided.

NSQHSS Survey

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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**

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

Developmental

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

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

NSQHSS Survey

Organisation : Darwin 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	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

NSQHSS Survey

Organisation : Darwin 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	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Developmental

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

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

NSQHSS Survey

Organisation : Darwin Private Hospital
Orgcode : 620277

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**