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

Holmesglen Private Hospital

Moorabbin, VIC

Organisation Code: 22 68 20

Survey Date: 30 January – 1 February 2017

ACHS Accreditation Status: **INTERIM ACCREDITATION**

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

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on-site survey.

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Survey Report

Survey Overview

The Holmesglen Private Hospital (HGPH) is a new build 147 bed hospital operated by Healthscope Limited (HSP). The hospital is situated in Moorabbin, a southern suburb of Melbourne and co-located on a site with the Holmesglen Institute. HSP currently has 11 co-located hospitals in Australia. HSP has recently closed Como Hospital with 53 beds for 12 months to allow for refurbishment and change it to a rehabilitation hospital. This has allowed for a 98% transfer of Como staff to the HGPH site plus at the time of the Interim survey 50% of the staff were new to HGPH.

The partnership with Holmesglen Institute is aimed at driving innovation and applied research across both the Institute and HGPH and nationally with Healthscope and in providing staff access to world class simulation facilities and quality education. It will also provide the Holmesglen Institute students with Graduate employment opportunities and clinical placements.

There is a 24/7 Emergency Department, seven (7) Theatres, a 9-bed Coronary Care Unit (CCU), 6-bed Intensive Care Unit (CCU) and a Cardiac Catheter laboratory. HGPH services will include General Surgery and Medicine, Gynaecology, Neurosurgery, Oncology, Ear Nose & Throat Surgery and Rehabilitation services.

HGPH Support Services include a Cardiac Rehabilitation Program, Diagnostic Imaging, Pathology, Pharmacy and Physiotherapy.

Three focus areas for the Executive prior to opening the HGPH were on current and past Healthscope patients and future patients, families, carers and the local community. Visiting Medical Officers (VMOs), Surgeons, General Practitioners (GPs) and Specialists, and current and new staff were also part of the information sharing on the introduction of the new services.

Marketing material was developed with feedback received and discussed, local clubs visited and the Department of Veteran Affairs (DVA) Victoria Police, Ambulance Victoria and the Fire Service were contacted and tours conducted. Focus groups and surveys were implemented with 90% rating a high level of patient satisfaction with the new hospital with a further focus group following the opening in February 2017.

Engagement of new Specialists commenced in 2015 with 100+ newly credentialled VMOs now in place. There is high level of uptake of permanent and sessional suites with 67% of the 70 available theatre sessions currently allocated.

The Holmesglen Private Hospital (HGPH) underwent a three day ACHS Interim Survey completing on the 1st of February 2017 with all Standards and applicable Actions being Satisfactorily Met. HGPH will undertake an ACHS Organisation-Wide Survey in December 2017 where the 69 Non-Applicable Actions for the Interim Survey will also be included.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The Healthscope (HSP) Clinical Governance Framework for Safety and Quality outlines the requirements for all HSP Hospital By-Laws and the HSP Quality and the Holmesglen Private Hospital (HGPH) Quality Plan for 2016/2017. The HSP Corporate Document Controller (CDC) is responsible for the management of Corporate Policies and Procedures.

The HGPH compliance with all policies is monitored by the HGPH document controller according to the risk rating of each policy with the higher risk policies requiring additional monitoring methods to ensure continuing compliance.

The three yearly HGPH Strategic Plan is inclusive of the HGPH Quality Plan with a strong focus on patient safety with the HGPH Safety and Quality Plan reflecting the Corporate Safety and Quality Plan to ensure compliance with policies, National Standards criteria, risk reduction and assisting with incident management.

The HGPH meeting templates and Terms of Reference (TOR) for all meetings reflect patient safety and quality.

At the time of the Interim Survey the planned meetings had not commenced but the survey team sighted the HGPH meeting calendar identifying the 19 meetings across all the National Standards that were to commence.

There has been an extensive project undertaken on the orientation of staff to the new hospital with all staff advised of the eLearning and mandatory training requirements. The general orientation program was followed by specific orientation to the workplace. Tours were held for the Como Hospital staff who were transferring to HGPH prior to the opening of the new hospital. All mandatory training attendance is monitored on a data base with education tools available to staff on the intranet.

Actions 1.2.2, 1.4.4, 1.5.2 and 1.6.2 are non-applicable (N/A) for initial 12 months.

Clinical practice

HGPH have documented clinical guidelines and pathways that are monitored and available to the clinical staff. The relevant clinical pathways are available in the clinical units with HGPH Care Plans recording Day 1, Day 5 and Day 7. ARC resuscitation guidelines and access to best practice guidelines are available on the public database, on HINT, MIMS and by adherence to the National Standards.

All clinical pathways are registered with review dates and who will have oversight of the review with HSP Clinical Clusters discussing relevant pathways and guidelines.

HGPH has in place an Admission Exclusion policy plus an Admission Exclusion criteria for Paediatrics as a component of the Paediatric Emergency Department (ED) policy.

Performance and skills management

HSP have robust systems in place to ensure all staff and Visiting Medical officers (VMOs) are credentialled appropriately either via the HSP By-Laws or HSP policies. An e-credentialling platform and an e-credentialling cluster is in place with HGPH representation. The Scope of Practice for VMOs is defined by their registration and insurance status as per the webPas register with all clinicians also defined by their registration e.g. AHPRA.

Quality KPIs cover credentialling and all position descriptions denote Scope of Practice and are available on the hospital document control system. Relevant staff have access to WebPas to enable a check on a VMOs current status if required.

Actions 1.11.2 and 1.13.2 are N/A (initial 12 months).

Incident and complaints management

HGPH has a system in place that manages, investigates and analyses incidents including near misses with action taken to reduce all risks identified through the RiskMan system and are subject to review by the HGPH Executive and the Medical Advisory Board. All staff were trained at the HGPH orientation on incident management and reporting. Relevant reports (e.g. shared learnings) and monthly alerts will be tabled at the MAC, Quality, Work Health & Safety (WH&S) and Clinical Governance and departmental meetings.

Any sentinel event or serious incident which occurs is elevated via the HSP chain of command both verbally and by the email alert system. Analysis of incidents can be subject to a debriefing of staff, medication reflection tools, shared learnings, and HGPH and HSP cluster reports. Mortality reviews-MAC meeting Minutes and RiskMan trend reports will be available.

Actions 1.14.3, 1.14.4 and 1.15.3 are N/A (initial 12 months).

Patient rights and engagement

HGPH adheres to the Charter of Patients' Rights that is consistent with the National Charter with systems in place to support and assist any patient/carer or family who do not understand their healthcare rights. Patients are provided if requested with information on developing an Advance Care Plan.

A system is in place to monitor consent and protect the privacy of all HGPH patients.

The Charter is displayed in the front reception area with brochures available in patient lounges and in each ward with information available in other languages as required. The patient compendiums available at the patient's bedside have information on Rights and Responsibilities with a documentation audit scheduled for HGPH to ascertain if patients are aware of their Rights and Responsibilities.

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

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	N/A	N/A
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	N/A	N/A
1.5.1	SM	SM
1.5.2	N/A	N/A
1.6.1	SM	SM
1.6.2	N/A	N/A

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	N/A	N/A
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	N/A	N/A

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

HGPH have sought feedback following tours of the new hospital from participating consumers and the Corporate Consumer Group will have now a HGPH consumer attending meetings.

Healthscope (HSP) have in place a number of policies and procedures demonstrating a commitment to the involvement of consumers as part of their Clinical Governance framework. Holmesglen (HGPH) also have in place consumer participation as part of their clinical governance framework.

Consumer engagement is a component of the annual audit schedule and there is a consumer engagement toolkit as a reference for HGPH staff. As the services at HGPH progress consumers and carers will become more actively involved in decision making about safety and quality.

Actions 2.1.2, 2.2.2, 2.3.1 and 2.4.2 are N/A (initial 12 months).

Consumer partnership in designing care

HSP and HGPH will continue to engage with consumers in the design of care and its delivery to meet the needs of all patients. Patient Satisfaction Surveys (PSS) will be conducted quarterly and action plans will be developed as required.

Action 2.6.2 is N/A (initial 12 months).

Consumer partnership in service measurement and evaluation

HSP has in place a number of initiatives and strategies to ensure the community and consumers are informed of HSP's continuing Safety and Quality performance. These include MYHealthscope & MYHealthscope websites which include clinical outcome data. The HSP Annual Report also includes information on Safety and Quality performance. Continuing Patient Focus Forums and Patient Satisfaction Surveys are all contributors to ensuring the community and consumers are aware of and have information on past performance, latest data and projects which are in place.

Actions 2.8.1 and 2.8.2 are N/A for initial 12 months.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	SM
2.1.2	N/A	N/A
2.2.1	SM	SM
2.2.2	N/A	N/A
2.3.1	N/A	N/A
2.4.1	SM	SM
2.4.2	N/A	N/A

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	N/A	N/A

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	N/A	N/A
2.8.2	N/A	N/A
2.9.1	SM	SM
2.9.2	N/A	N/A

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

A Holmesglen Private Hospital (HGPH) Infection Prevention & Control (IP&C) Committee has not yet met surveyors noted that a meeting has been scheduled for mid-February 2017. The IP&C committee will report to the Quality & Risk Committee and the Medical Advisory Committee (MAC). The IP&C Nurse participates in the Healthscope Cluster meetings where the cluster learnings are shared across all Healthscope national sites.

Regular HGPH IP&C reporting will be required by the Healthscope Corporate office. The February IP&C agenda includes formulating the Terms of Reference, membership (which will include an Executive member), developing risk assessment & plans for antimicrobial stewardship direction and developing more strategies to further increase communication with patients and carers.

HGPH employs a 0.63 FTE dedicated Infection Prevention & Control nurse, who has a background in peri-operative nursing, is a qualified nurse immuniser and has undertaken the ten (10) Commission IP&C modules.

There are plans to provide education to the Gold Standard level for hand hygiene auditing as well as having an Infection Control “champion” in each ward and department. In addition, HGPH is supported by an experienced HICMR (Health Infection Control Management Resources) practitioner and surveyors were advised that she will Chair the new committee.

HICMR policies guide HGPH staff in conjunction with Healthscope IP&C policies. Surveyors noted that all IP&C Policies are subject to a three yearly review.

Staff have access to Healthscope, HICMR and HGPH IP&C policies online. A hard copy IP&C resource folder is available in each department and includes guidance for the management of patients and the identifying signage required for special prevention measures. Surveyors noted the schedule in place for the surveillance of health care associated infections and HAI risk program.

Actions 3.1.4, 3.4.1, 3.4.2 and 3.4.3 are N/A (initial 12 months).

Infection prevention and control strategies

Hand hygiene competency is mandated for all HGPH staff at orientation. There is an e-learning package available and prior to commencing placement at HGPH all students are required to provide evidence that they have completed the Hand Hygiene Australia’s competency.

Surveyors noted promotion of hand hygiene on site public television screens and the extensive availability of GoJo hand wash products. There is a schedule for auditing hand hygiene and surveyors were advised that any non-compliance will be addressed via an action plan.

Compliance rates are to be tabled at the IP &C Committee and will be forwarded to Healthscope Corporate as required. HGPH will participate in the aligned ACHS Clinical indicators. There is good compliance with Cat A workforce immunisation requirements.

Agreements are in place with documented placement contracts including the credentialling process for medical staff. Policies guide the management of occupational communicable disease status, occupational allergies and the use of Personal Protective Equipment (PPE).

Surveyors were advised that whilst there is an evaluation of the new products and procedures process, the purchase decisions for the vast range of new equipment provided for HGPH was made via the procurement team in Healthscope's Corporate office.

There is a schedule and process in place for monitoring the use and management of invasive devices with significant education undertaken with more education planned. There is a mandatory requirement at HGPH for all clinical staff to complete the Aseptic Technique competency and this is provided for nurses and relevant allied health staff at orientation and is to be further assessed annually. HGPH are considering developing a plan as per advisory A13/05 for Credentialled and Visiting Medical Officers (VMOs) pending further discussion at the first Medical Advisory Committee in February 2017.

Action 3.10.3 is N/A initial 12 months.

Managing patients with infections or colonisations

A system of precautions is in place to prevent infection transmission and is consistent with current national guidelines. The IP &C Nurse audits every patient identified with infection or colonisation, with the Hospital Co-ordinator undertaking a risk analysis to determine the most appropriate accommodation and equipment/cleaning requirements for the patient. Whilst there is a good supply of single rooms with ensuite bathrooms, HGPH does not have any negative pressure rooms and patients assessed as requiring this accommodation would be subject to transfer.

A Risk assessment is completed on every admission and alerts are actioned as appropriate. There is provision on the patient transfer document to alert other service providers of any IP&C alerts they need to be aware of prior and post transfer. Surveyors also noted that the six monthly minimum data set required by Healthscope includes the occurrence of wound infections after hip/ knee prosthesis, VRE, occupational exposure to body fluids and blood & non parental fluids**.**

Action 3.11.3 and 3.11.5 are N/A initial 12 months.

Antimicrobial stewardship

Whilst there has not yet been a meeting yet for Antimicrobial Stewardship (AMS), all wards and departments have access to the antibiotic guidelines on HINT and the "traffic light" restricted antibiotic flowchart. The Pharmacy service is monitoring antibiotic usage and will check individual pathology results if a "red" antibiotic is ordered.

HGPH has also registered to participate in the November 2017 NAPS (National Antimicrobial Prescribing Survey). A microbiologist will attend the first meeting of IP&C Committee and it is yet to be determined if a separate committee will be developed for AMS or it will remain within the IP&C Committee.

Cleaning, disinfection and sterilisation

A risk management approach has been used in developing systems to maintain a clean and hygienic environment for patients and staff. The surveyors were impressed at the high standard of cleanliness everywhere, albeit it is a brand new facility, whilst acknowledging the cleaning necessary to be undertaken prior to occupancy. Cleaning schedules are in place and noted was the effective use of flat mops, including a spotlessly clean dedicated area for their laundering. Surveyors noted various competencies for the environmental staff including damp dusting and cleaning floors.

Audits have been undertaken of “household” items with linen supplied by an external contractor and the clean delivery and distribution is well segregated from the soiled pick up and storage system.

There is an excellent flow of food delivery (pre-cooked and cryo packed), short orders, meal reconstitution, servery, distribution, after meal collection and crockery/utensil cleaning with absolute separation between the clean and dirty areas.

A large Central Sterilising Department (CSD) is fitted with very impressive new equipment and complies with all National and International Standards including AS/NZS 4187/ 2014. There is a large Steelco washer which includes ultrasonic cleaning as well as two smaller Steelco cleaner/washers. Minimisation of manual handling with safety obviously addressed well, e.g. central closed dosing system for all detergents and chemicals. There are three International Sterilisers with delivery to a large sterile storage area complete with a compactus completing the flow of dirty to sterilised instruments. All flexible scopes are treated via Plaztek (Sterrard) system which includes contained adjacent storage systems.

The department is headed by an enthusiastic highly experienced staff member who holds a Certificate 3 and a Certificate 4 in sterilisation. There are five other permanent workers who all hold as a minimum a Certificate 3 in sterilisation The team provides a service Monday to Friday 0700-2200 plus on call to service theatres and the Emergency Department (ED). There is a batch tracking system (MaQ) in place and regular audits are scheduled. There has been an obvious effort to reduce waste including the recycling of blue wraps, and a new Neptune fluid disposal system.

A waste audit conducted in January showed 92% compliance. There is good patient flow and staff access to each of the seven theatres though the transfer of used theatre instruments to CSSD on covered trolleys is to be risk accessed by HICMR in February 2017 this was discussed with the HGPH Executive and Theatre Manager during survey.

Communicating with patients and carers

Both actions in this criterion are N/A for Interim Accreditation.

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	N/A	N/A
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	N/A	N/A
3.4.2	N/A	N/A
3.4.3	N/A	N/A

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	N/A	N/A

Action 3.10.1 Core

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

Surveyor Comment:

There is a mandatory requirement that all HGPH clinical staff complete an aseptic technique competency. This is provided for nurses and relevant allied health staff at orientation and will be assessed annually. The surveyors noted that HGPH were considering developing a plan as per advisory A13/05 for credentialled and Visiting Medical Officers (VMOs) after the first Medical Advisory Committee in February 2017. Dependent on the decision of the MAC regarding VMOs this may be introduced.

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	N/A	N/A
3.11.4	SM	SM
3.11.5	N/A	N/A
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	N/A	N/A

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	N/A	N/A
3.19.2	N/A	N/A

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

HGPH has in place policies procedures and protocols for the implementation and maintenance of the medication safety system. The policies and procedures and protocols reflect legislative, jurisdictional, national and professional guidelines. Medication incident reporting is via RiskMan with reporting to the Medication Safety Committee. Medication incident reporting outcomes are distributed to the Executive and Departmental Managers. HGPH has systems in place to reduce the risk of adverse medication incidents via education, reporting sentinel events process, therapeutic guidelines, antibiotic guides and a medication reflection tool to assist with review and practice.

Reference and update was given by the survey team on the Australian Commission on Safety and Quality in Health Care recent release of Advisory No 16/04 on differences between the Medication Management Plan (MMP) and the Consumer Medication (Action) Plan (CMAP) details to meet action 4.14.1.

Actions 4.2.2, 4.3.3, 4.4.2 and 4.5.2 are all N/A for initial 12 months.

Documentation of patient information

A best possible medication history is documented for every patient with identified medication allergies and any adverse drug reactions documented in the clinical record which is available at the point of care. All adverse drug reactions are reported to the Therapeutic Drugs Administration.

All medication/s are documented and reconciled at admission and any transfer of care.

A medication history section is a component of the patient's admission pack with a pre-admission medication history obtained for all elective admissions. Medication profiles are available and the Nursing Discharge Summary has a section to be completed on medication.

Action 4.7.2 is N/A (initial 12 months).

Medication management processes

In place are eMIMS and Therapeutic Guidelines both on line an Injectable handbook in all departments, access to NPS Medicine Wise Line and advice-ED. The on-site pharmacy, brochures and fact sheets on medication for consumers are all available for clinicians.

Systems are in place for the disposal of all medicines including Cytotoxic agents. All discarded amounts of a drug are either recorded in the DD book or are removed and discarded by the Clinical pharmacist.

Audits occur by the Department of Health Drugs and Poisons Unit. Clinical Pharmacists monitor the Imprest System and the expiry dates of all medicines.

Actions 4.9.3, 4.10.3 and 4.11.2 are N/A for initial 12 months.

Continuity of medication management

The discharge medication profiles are completed by the clinical pharmacist a copy given to the patient and a copy faxed to the referring General Practitioner. Ceased and withheld medications are also part of the patient's profile on discharge.

Compliance with patients receiving medication profiles on discharge is subject to audit.

Communicating with patients and carers

The clinical workforce including the VMO and Clinical Pharmacist provide patient specific medicine information to patients on discharge including the benefits and any associated risks or side effects they need to be aware of. The discharge medication profile given to the patient and filed in the clinical record. The Clinical Pharmacist provides education to patients both during admission and at discharge. Specific information is given on e.g. Warfarin and chemotherapy medication.

A High Risk Medication Checklist audit is conducted via the Medication Safety Committee.

The MyHealthscope website also provides a link to the Better Health channel for consumers.

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	N/A	N/A
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	N/A	N/A
4.4.1	SM	SM
4.4.2	N/A	N/A
4.5.1	SM	SM
4.5.2	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
4.11.1	SM	SM
4.11.2	N/A	N/A

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual

Healthscope Policy No.2.08 meets the national specifications for patient identification bands and requires not three but four identifiers. It also prescribes a number of risks which require the use of a red arm band rather than the plain white arm band. When a red arm band is used, this alert is documented on alert sheet MHR000 at the front of the patient's medical record and on the WebPas. An arm band is generated on presentation to the ward (including infusion ward and the Day Stay area) and non-elective patients on presentation to the emergency department by the triage nurse.

These identifiers are used when care, therapy, or investigations are performed including handovers, transfer and when discharge documentation is produced. The policy is identified as a very high risk policy which requires regular site auditing, reporting of compliance via KPI to Healthscope corporate and the provision of an eLearning module.

Surveyors noted the surgical safety check list documentation as well as observing time out and procedure matching in the operating theatre with accompanying documentation which requires both the surgeon's and nurses' signature. They were impressed that time out has also been introduced into the process of blood administration and documentation verified that this is occurring.

Reports of duplicate names or similar are flagged on the computer screen and green stickers are used on patient history and other areas to alert staff with any incident involving mismatching events reported on Risk Man and subject to investigation and analysis.

Actions 5.1.1 and 5.2.2 are N/A (initial 12 months).

Processes to transfer care

Holmesglen Private Hospital (HGPH) introduced an orange slip to be used by non-clinical staff e.g. orderly's when transporting patients between departments. In addition, theatre provides the orderly with a print off of the patient's label which they check with the patient in day of surgery area prior to accompanying them to the operating theatre. There is also a documented process in the anaesthetic room when transferring care. A new process has also been introduced for radiology requests with a scanned request being sent to radiology and the original accompanying the patient to the radiology department for the procedure.

Processes to match patients and their care

The clinical handover prompt sheet includes identification checks and specific documentation for both ward to ward and inter hospital transfer. Audits are scheduled to monitor the patient matching system. A consent process for clinical photography is also in place.

Action 5.5.3 is N/A (initial 12 months).

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	N/A	N/A
5.2.1	SM	SM
5.2.2	N/A	N/A
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	N/A	N/A

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

There are a range of HSP policies and procedures in place; these include departmental and intra unit admission and discharge transfers, transporting a critically ill patient and admission procedures to the catheter laboratory. A Clinical Handover PowerPoint presentation is available for staff and clinical handover processes at HGPH are a component of the orientation program. The radiology transport handover and procedures involving Ambulance Victoria are also in place. All clinical handover policies are subject to regular monitoring and action is taken to maximise the effectiveness of all handovers occurring across HGPH.

Action 6.1.2 is N/A (initial 12 months).

Clinical handover processes

A clinical handover was observed by the survey team involving both the initial group and the bed-side handovers. Electronic handovers reports are available for staff and the use of the whiteboards situated in every patient's rooms are all tools for use in ensuring an effective information is available for patients and families as required.

Clinical handovers using the ISOBAR principles are used in all clinical settings.

Actions 6.3.3 and 6.4.2 are N/A for the initial 12 months.

Patient and carer involvement in clinical handover

This criterion is N/A for the initial 12 months.

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	N/A	N/A
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	N/A	N/A
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	N/A	N/A

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	N/A	N/A

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

A Holmesglen Private Hospital (HGPH) staff member belongs to the Healthscope Transfusion Governance cluster which develops and reviews all policies relating to blood management. It meets four times per year and monitors all transfusion practices. Surveyors noted policy No. 8.64 covers all aspects of blood management including managing reaction, cold chain management, consent process, patient managing, the Jehovah Witness patient, the child without parental consent, emergency uncross matched red cells, massive blood transfusion and unused blood management with an annual blood audit scheduled. All blood reactions and other blood related incidents are reported via Risk Man, which are analysed and reported to the HGPH Quality and Risk Committee. Holmesglen participates in Blood Net reporting**.**

Actions 7.1.3, 7.2.2 and 7.4.1 are N/A for initial 12 months.

Documenting patient information

Blood transfusion documentation HMR 10.8 requires the completion of best possible history of blood product usage and also contains the blood prescription and transfusion record. Any adverse reactions are recorded in the patient record. Adverse reactions are entered in Risk Man and Pathology is advised. A Blood Transfusion Care Plan is in use and an audit of records is scheduled annually. Surveyors noted that a HGPH Transfusion Committee meeting is scheduled to be held in combination with the Clinical Deterioration committee.

Actions 7.5.3 and 7.6.2 are N/A for initial 12 months.

Managing blood and blood product safety

Blood Safe eLearning Australia is an annual Healthscope clinical competency required for all nurses involved in blood administration. Surveyors were impressed that Healthscope had introduced Time Out in the checking process for blood administration. HGPH is able to minimise blood wastage with rotation of products with the nearby Healthscope Knox Hospital. HGPH have distributed to staff the Red Cross cards which table adverse events and also Department of Health and Human Services (DHHS) blood matters cards promoting Ask, Before, Confirm and Declaration. Currently blood is stored only in the pathology refrigerator which is appropriately monitored and alarmed.

A large new blood fridge is soon to be commissioned within the operating theatre.

Actions 7.7.2 and 7.8.2 are N/A for initial 12 months.

Communicating with patients and carers

The nurse is required to sign the care plan that patient has received information and explanation around the receiving of a blood transfusion with a consent to receiving blood required. Surveyors noted the availability of Red Cross fact sheets, the NSW Health Blood Myths Busted sheet, and SA fact sheet for distribution to patient and carers.

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	N/A	N/A
7.2.1	SM	SM
7.2.2	N/A	N/A
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	N/A	N/A

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	N/A	N/A
7.6.1	SM	SM
7.6.2	N/A	N/A
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	N/A	N/A
7.8.1	SM	SM
7.8.2	N/A	N/A

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

Surveyors noted that the Committee Meeting Plan 2017 has scheduled a combined Pressure Prevention and Falls Prevention meeting to be held second monthly. Holmesglen Private Hospital (HGPH) also participates in the HSP Pressure Prevention cluster meeting where any learnings are shared.

Healthscope policies (in particular No.8.05) and protocols subject to regular review are based on current best practice guidelines to continue to inform clinical practice at HGPH. All pressure areas are reported on Riskman with analysis being presented to Quality & Risk committee and the MAC.

All Stage 2 and above pressure injuries are reviewed by the HGPH wound consultant.

There are twice yearly reports contributed to the ACHS clinical indicator data set report and quarterly reporting to Healthscope Corporate re hospital acquired pressure injuries. All beds at HGPH are new and fitted with pressure preventing high density mattresses. There is also a range of equipment available to implement prevention strategies including air mattresses, RoHo cushions, Spenco booties, heel lifters, prevention silicone pad dressings, slide sheets (to prevent shearing injuries), as well as “Steady Sarah” and lifting machines. Although there is limited equipment at this stage to manage the Bariatric patient, HGPH plans to limit elective admissions until they increase the range of Bariatric equipment. Surveyors noted that Pressure Injury Prevention is an agenda item for all department meetings.

Actions 8.2.4 and 8.3.1 are N/A for initial 12 months.

Preventing pressure injuries

A modified Waterlow risk assessment is completed on admission and daily thereafter. This is a comprehensive skin assessment (HMR 6.12) which informs the wound care plan HMR 7.12.

It is planned to also undertake these assessments in the Emergency Department. All elective patients are assessed in DOS (Day of Surgery) ward if not completed in preadmission clinic and HGPH is fortunate to have an experienced specialised wound care RN (Division 1) 0.63eft and a 0.21eft RN (Division 2) who are an excellent resource and follow up any “at risk” patients.

Nursing wound prevention techniques in practice include “rounding” which is charted as is “turning” on the Care Plan chart. Surveyors noted that auditing of at risk patient screening and review of pressure injury prevention plans is scheduled and an in-service around products and equipment is scheduled for 2017 Transfer and discharge documentation ensures that information about those identified at risk should be passed from one health team to the next.

Actions 8.5.3, 8.6.3, 8.7.4 and 8.8.4 are N/A for initial 12 months.

Managing pressure injuries

A range of approved (by Wound Care nurse) products is available and policies determine that their management is in keeping with best practice. As required specialised equipment may be hired via the patients’ health insurance.

Compliance with pressure injury management plans is subject to audit with all high risk patients referred to the dietician and every patient who has a Category 1 on admission is referred to the Wound Consultant.

Communicating with patients and carers

Surveyors were advised that there was a range of information leaflets available for patients including DHHS Move, Move, Move with Care Plans discussed with patient and carers though staff indicated an advantage would be if their understanding was confirmed by a signature on the Care Plan. This may be an item HGPH can explore via the Pressure Injury & Prevention and Falls Committee as it progresses.

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	N/A	N/A
8.3.1	N/A	N/A
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	N/A	N/A
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	N/A	N/A
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	N/A	N/A

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	N/A	N/A

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.

Healthscope conducts cluster meetings for Recognising and Responding to Clinical Deterioration. A committee, combined with the Transfusion Committee plans to have its first Holmesglen Private Hospital (HGPH) meeting on the 16th February 2017 and plans to include a medical representative from the Critical Care area. There has been a working committee, chaired by the Unit Manager of Intensive care, which has established organisation wide processes in the new HGPH facility. The Healthscope policies and procedures are in place and there are protocols regarding documentation of the escalation of care, a rapid response system and extensive communication about clinical deterioration. Although at the time of survey no MET calls had been made there is a schedule in place which will ensure every MET call will be evaluated, and a mortality/morbidity reported to the MAC. The HMR 7 will be utilised for Emergency Response Data collection including the patient's condition six hours prior to the event.

Action 9.2.4 is N/A for initial 12 months.

Recognising clinical deterioration and escalating care

The Between the Flags Adult observation sheet is in use though out the organisation and surveyors were advised that HGPH Emergency department was awaiting delivery of Between the Flags documentation for various child age groups. Action required when care is to be escalated is outlined within the documentation. There is an audit of observations charts scheduled though the surveyors felt that this needed to be more regular than once a year and advice was given to this effect. There have been mock trials of escalating care and calling for emergency assistance where there is concern about a patient condition with these subject to audit.

Actions 9.3.3 and 9.4.3 are N/A for initial 12 months.

Responding to clinical deterioration

All staff are informed about emergency response at the time of orientation. Any collapse of visitors, staff or patients not admitted (e.g. in consulting rooms) will be transported to the Emergency Department for treatment.

Criterion used includes Failure to Act amongst the schedule of audits which will be performed. All MET calls are entered on RiskMan and will be audited quarterly. All employed staff are required to undertake the mandatory annual BLS and currently 92% of staff have completed this competency at the time of the Interim Survey.

HGPH is considering VMO BLS training and surveyors were advised that a plan to address this will be developed following the outcome at the first Medical Advisory Committee (MAC) to be held in February 2017.

HGPH is well resourced with Advanced Life Support practitioners. There is a 24/7 coverage by the Intensive Medical Fellow in Critical Care (there is also a Consultant on call all of whom have ALS within their credentialling requirements) including all After Hours co-ordinators, NUMs and AssNUMs.

There are well-stocked resuscitation carts in each clinical area which surveyors observed to be regularly checked. All resuscitation trolley drugs are stocked in secure container and under the imprest system from Pharmacy who ensure all used drugs are replaced and currency in maintained. ED has the equipment setups for paediatrics and neonates resuscitation in place.

Communicating with patients and carers

Information for patients and their carers is contained within the bedside compendium with HGPH planning to undertake community education for Code Worry, but in the meantime relatives are involved in care pathways, handover and hourly rounds. Should a relative/visitor initiate an escalation of care this will be noted within the Risk Man report.

HGPH has been proactive in visits to GPs, particularly those who service local nursing homes, to advocate the development of Advanced Care Plans. Currently no staff member has been trained to address this but encourage the patient's doctor to have the relevant discussion with their patients, particularly after an emergency or if within Intensive Care department. HGPH has established a system for MET call review as well as EAP (Staff Assistance Program) when required.

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	N/A	N/A

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	N/A	N/A
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	N/A	N/A

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:

All employed staff are required to undertake the mandatory annual BLS and currently 92% of staff have completed this competency. HGPH is considering BLS for VMOs and surveyors were advised that a plan to address this will be developed following the outcome at the first MAC to be held in February 2017.

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

HGPH has in place policies, procedures and protocols that are consistent with best practice guidelines and incorporate screening and assessment tools to ensure that falls recognition and prevention strategies are in place for every identified falls risk patient.

All falls incidents are reported on RiskMan and reported to the Falls Cluster, Falls Committee, the Quality/Consumer Forum Committee, clinical ward meetings and the HGPH Medical Advisory Board.

Falls incidents are reported quarterly via HSP Clinical KPIs and 6/12 ACHS Clinical Indicators.

Actions 10.2.4 and 10.3.1 are N/A for initial 12 months.

Screening and assessing risks of falls and harm from falling

HGPH demonstrated an awareness of the at risk patient groups including the risk of patients falling in the over 75yr age group. The Falls risk assessment is a component of the comprehensive risk assessment which is conducted on all day and multi-day patients on admission and at least daily as per the policy.

The FRAT tool is the tool of choice and eLearning education in falls prevention is a component of the education calendar.

The orientation program also contains a component on falls assessment and prevention.

Actions 10.5.3 and 10.6.3 are N/A for initial 12 months.

Preventing falls and harm from falling

Falls prevention as assessed for each patient is documented in the clinical record. A falls prevention plan is developed for a falls risk patient is documented and regularly monitored with progress and intervention clearly entered in the patient's daily progress notes. Care plans and pathways are documented with patient education and rehabilitation assessment implemented as required. An updated falls and mobility assessment is conducted for an at risk patient prior to a transfer and prior to any clinical handover.

Action 10.7.3 is N/A for initial 12 months.

Communicating with patients and carers

HGPH has falls information provided to patients via brochures the MyHealthscope website, with the patient care whiteboards updated re falls prevention information by clinical staff. The bed-side clinical handover engages patients' cares/families in the discussion about the importance of falls prevention.

Nursing care plans are signed by the patient and involvement of the medical practitioner and allied health staff is actioned as required.

Discharge planning conferences occur with patients and families if required.

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	N/A	N/A
10.3.1	N/A	N/A
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	N/A	N/A
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	N/A	N/A

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	N/A	N/A
10.8.1	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Holmesglen Private Hospital
Orgcode : 226820

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM

1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	N/A	N/A
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	N/A	N/A

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	N/A	N/A
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	N/A	N/A
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in	SM	SM

	response to complaints		
1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	N/A	N/A
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	N/A	N/A
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	N/A	N/A
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership	N/A	N/A

	role		
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	N/A	N/A

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	N/A	N/A

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	N/A	N/A
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	N/A	N/A
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	N/A	N/A

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	SM	SM

	• single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	N/A	N/A
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	N/A	N/A
3.4.2	Compliance with changes in practice are monitored	N/A	N/A
3.4.3	The effectiveness of changes to practice are evaluated	N/A	N/A

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	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	SM	SM

- waste management within the clinical environment
- laundry and linen transportation, cleaning and storage
- appropriate use of personal protective equipment

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

Communicating with patients and carers

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

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	SM	SM

	comprehensive list of medicines and explanation of changes in medicines		
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	N/A	N/A
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	N/A	N/A
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, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	N/A	N/A
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	N/A	N/A
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	N/A	N/A
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	N/A	N/A

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	N/A	N/A

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 • communication about clinical deterioration	SM	SM
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these 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	N/A	N/A

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 ressure, 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	N/A	N/A
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	N/A	N/A

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

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	SM	SM

	organisation		
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	N/A	N/A
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	N/A	N/A
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

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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Recommendations from Current Survey

There are no current recommendations.

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Recommendations from Previous Survey

There are no previous recommendations.

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	36	9	45
Standard 2	0	3	8	11
Standard 3	0	31	10	41
Standard 4	0	23	8	31
Standard 5	0	6	3	9
Standard 6	0	6	4	10
Standard 7	0	13	7	20
Standard 8	0	15	6	21
Standard 9	0	12	3	15
Standard 10	0	13	5	18
Total	**0**	**158**	**63**	**221**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	8	0	8
Standard 2	0	4	0	4
Standard 3	0	0	0	0
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	1	0	1
Standard 7	0	3	0	3
Standard 8	0	3	0	3
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**35**	**0**	**35**

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Standard	SM	MM	Total
Standard 1	36	0	36
Standard 2	3	0	3
Standard 3	31	0	31
Standard 4	23	0	23
Standard 5	6	0	6
Standard 6	6	0	6
Standard 7	13	0	13
Standard 8	15	0	15
Standard 9	12	0	12
Standard 10	13	0	13
Total	**158**	**0**	**158**

Standard	SM	MM	Total
Standard 1	8	0	8
Standard 2	4	0	4
Standard 3	0	0	0
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	1	0	1
Standard 7	3	0	3
Standard 8	3	0	3
Standard 9	8	0	8
Standard 10	2	0	2
Total	**35**	**0**	**35**

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	44	9	53	Met
Standard 2	0	7	8	15	Met
Standard 3	0	31	10	41	Met
Standard 4	0	29	8	37	Met
Standard 5	0	6	3	9	Met
Standard 6	0	7	4	11	Met
Standard 7	0	16	7	23	Met
Standard 8	0	18	6	24	Met
Standard 9	0	20	3	23	Met
Standard 10	0	15	5	20	Met
Total	**0**	**193**	**63**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	44	0	44	Met
Standard 2	7	0	7	Met
Standard 3	31	0	31	Met
Standard 4	29	0	29	Met
Standard 5	6	0	6	Met
Standard 6	7	0	7	Met
Standard 7	16	0	16	Met
Standard 8	18	0	18	Met
Standard 9	20	0	20	Met
Standard 10	15	0	15	Met
Total	**193**	**0**	**193**	**Met**

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	36	9	45
Standard 2	0	3	8	11
Standard 3	0	31	10	41
Standard 4	0	23	8	31
Standard 5	0	6	3	9
Standard 6	0	6	4	10
Standard 7	0	13	7	20
Standard 8	0	15	6	21
Standard 9	0	12	3	15
Standard 10	0	13	5	18
Total	**0**	**158**	**63**	**221**

Standard	SM	MM	Total
Standard 1	36	0	36
Standard 2	3	0	3
Standard 3	31	0	31
Standard 4	23	0	23
Standard 5	6	0	6
Standard 6	6	0	6
Standard 7	13	0	13
Standard 8	15	0	15
Standard 9	12	0	12
Standard 10	13	0	13
Total	**158**	**0**	**158**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	8	0	8
Standard 2	0	4	0	4
Standard 3	0	0	0	0
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	1	0	1
Standard 7	0	3	0	3
Standard 8	0	3	0	3
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**35**	**0**	**35**

Standard	SM	MM	Total
Standard 1	8	0	8
Standard 2	4	0	4
Standard 3	0	0	0
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	1	0	1
Standard 7	3	0	3
Standard 8	3	0	3
Standard 9	8	0	8
Standard 10	2	0	2
Total	**35**	**0**	**35**

NSQHSS Interim Accreditation

Organisation : Holmesglen Private Hospital
Orgcode : 226820

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	44	9	53	Met
Standard 2	0	7	8	15	Met
Standard 3	0	31	10	41	Met
Standard 4	0	29	8	37	Met
Standard 5	0	6	3	9	Met
Standard 6	0	7	4	11	Met
Standard 7	0	16	7	23	Met
Standard 8	0	18	6	24	Met
Standard 9	0	20	3	23	Met
Standard 10	0	15	5	20	Met
Total	**0**	**193**	**63**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	44	0	44	Met
Standard 2	7	0	7	Met
Standard 3	31	0	31	Met
Standard 4	29	0	29	Met
Standard 5	6	0	6	Met
Standard 6	7	0	7	Met
Standard 7	16	0	16	Met
Standard 8	18	0	18	Met
Standard 9	20	0	20	Met
Standard 10	15	0	15	Met
Total	**193**	**0**	**193**	**Met**