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

Hunter Valley Private Hospital

Shortland, NSW

Organisation Code: 12 03 08

Survey Date: 10 - 12 April 2018

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:

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

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Survey Report

Survey Overview

Hunter Valley Private Hospital provides acute medical, surgical and rehabilitation healthcare services in Newcastle, NSW. Recently purchased by one of Australia's largest private healthcare providers it has undergone significant change since last survey to accommodate the requirements of the new owner.

It was obvious to surveyors that the organisation is committed to quality and safety, and while originally purchased to provide a hub and spoke model for the nearby Newcastle Private Hospital not yet realised, places high value on meeting its own largely elderly population's specialised needs for acute medical and surgical care with onsite inpatient and day rehabilitation services.

The survey team was provided with a comprehensive self-assessment and had access onsite to policies, procedures and other relevant documents. All relevant clinical areas were visited, including partnering organisations such as Pharmacy to determine the effectiveness of the interface between.

HVPH is about to commence the creation of a new Strategic Plan, with clearly articulated goals and values espoused by an enthusiastic, cohesive and committed executive team under the Healthscope umbrella. Work done in the past two years has continued to lead to improvements in culture and clinical engagement which are palpable throughout the organisation. There is a strong focus on providing quality safe care to the patients within rigorous risk management and quality frameworks. Surveyors noted that the standard of clinical care is high and staff were generally very proud of their organisation. Patient survey results show high levels of satisfaction, as do staff and medical practitioner surveys.

The recommendations from the previous survey were reviewed and have all been closed. Staff have steadily improved processes associated with the ten National Standards and all actions, both core and developmental have been met on this occasion.

A number of suggestions have been made to assist the organisation in building on the safe, quality care it already provides but surveyors agree that HVPH is a responsive health service with a positive culture which values opportunities to continually improve in order to achieve high quality outcomes for its patients.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Hunter Valley Private Hospital (HVPH) is a small private facility providing low risk medical, surgical and rehabilitation services to its local community as part of the Healthscope Pty Ltd suite of hospitals, by whom it was purchased two and half years ago. Since this time, the hospital has been aligning its system of operations to the Healthscope model, including its system for policies and procedures. Currently, the organisation is in the final stages of reviewing its local policies to ensure they reflect Healthscope requirements and surveyors suggest that this process continues to be high priority until it is completed.

At survey, staff were able to demonstrate their ability to access relevant policies and procedures to the survey team. Policies were noted to be in date, with a clear process of ownership, review timeframe and executive sign off, including at corporate level. While the policies and procedures are maintained electronically, there are some hard copies kept as a business continuity strategy, and the organisation needs to be vigilant in ensuring that these are kept updated to avoid version control issues. Regular and ongoing evaluation demonstrates the effectiveness of this system. The low number of incidents related to non-compliance with policy affirms this.

Both its clinical governance framework and risk management framework are vigorously managed. Risk management is actively evolving, in line with corporate expectations and the Risk Register which is used to monitor and reduce the level of risk for the organisation has been recently reviewed. All risks are individually managed, with a clearly identified owner and a plan of action for mitigation and/or monitoring visible. There are no unit-based risk registers, where identified hazards are managed through the workplace health and safety (WHS) system. It is suggested however that staff, particularly nurse managers, receive comprehensive education in risk management to ensure that non WHS risks are formally escalated for inclusion on the hospital’s Risk Register.

Surveyors noted that clinical governance at hospital level is robust and that structures and processes are in place to record, review and escalate safety and quality concerns. RiskMan has recently been implemented and data collected via this system is being used by staff to identify areas for improvement for incidents (clinical and non-clinical), complaints and feedback.

The organisation’s committee structure is clear and unambiguous, with reporting and communication lines supported by appropriate terms of reference. Minutes of meetings are similarly clear and concise, with action plans developed to monitor achievement of actionable items. The Quality program is based on the National Standards, with committees for each standard reporting directly to the organisation’s Quality and Safety Committee, which is chaired by the Director of Nursing. Support is provided by the corporate Quality and Safety team. Corporate governance is maintained via a rigorously monitored system of key performance indicators in quality and safety to which general managers are held to account. All hospitals benefit from the Healthscope Shared Learnings Report, whereby the learnings acknowledged through an incident occurring at a particular hospital are disseminated to peer hospitals for proactive review of their own processes, leading to early identification of previously unseen risks.

Quality outcomes are available to the general public through the MyHealthscope web portal.

The survey team noted a number of examples of quality improvements, each of which were clearly defined, addressed through action plans and included evaluator mechanisms to measure their effectiveness. All clinical staff, agency nurses and locums were aware of their role and responsibilities relating to quality and safety with sound support structures in place.

An extensive education program is in place and staff have access to education and training both at orientation and ongoing, captured via the ELMO Learning Management System. Quality and safety is explicitly emphasised in all programs, including competency-based training. Position descriptions include quality and safety expectations. By completion of survey mandatory training rates met organisational and National Standards requirements but there is room for improvement in how HVPH monitors its staff's meeting of their obligations. Surveyors suggest that more attention is given to this area and that achievement of mandated training and competencies be explicitly included in performance review.

Clinical practice

There is a wide range of clinical pathways in use at the hospital and these have been reviewed in recent months (November 2017). Many of the existing pathways are being also updated to mirror the Healthscope national pathway templates. Monitoring of the application of the pathways and of the variances from the pathways is undertaken. Variances are recorded in a ward based variance sheet, and the quality governance systems then analyse the variance and the reasons and outcomes. Prior to admission and at time of admission all patients are screened for medical conditions that may place them at increased risk of harm. The assessments include risks of falls, medications, skin integrity, allergies and infectious diseases. These assessments are recorded in the patient's medical record. Compliance with the undertaking of a risk assessment is audited on an annual basis. If a risk is identified there is an alert sheet placed at the front of the patient's medical record and an action plan prepared to minimise the risk identified.

Policies and procedures are in place for the management of the deteriorating patient. Within the clinical areas there are patient call buttons and nurse assist call buttons for the first level of response. There are also red Emergency buttons that summon all senior staff including medical staff in the event of a major deterioration. Out-of-hours there are staff within the hospital that have been trained in advanced life support as well as there being medical staff call and the availability of an emergency transfer by the NSW Ambulance service.

The HVPH has a paper based medical record system and the availability of the medical record is ensured by the transport of the record with patient each time the patient moves within the facility. Old records are stored in a commercial storage facility off site. The format of the records allows for auditing processes. The hospital is also in the process of introducing more of the Healthscope nationally based medical record forms. There are regular audits for the records for completeness.

Performance and skills management

All senior medical staff at the hospital are credentialled via a national electronic system utilised by Healthscope. This encompasses the registration, insurance, medical qualifications and referee report documentation. All applications and reapplications are referred to the Medical Advisory Committee (MAC) for assessment and recommendations. There is a formal process for defining the scope of clinical practice for the medical staff - the scope for proceduralists being quite detailed. The scope of practice also reflects the hospital's capabilities and admission policies. New procedures or treatments are referred to the MAC for assessment and recommendation prior to being referred to the CEO for possible approval.

The Career Medical Officers (CMOs) employed in the daytime by the hospital are supervised by the attending specialists and the GM. It is suggested that the processes for assessing the application and reapplications for medical staff members also include a google (or equivalent) search and the gaining of information about immunisation/vaccination status. All staff are involved in an annual performance appraisal. There is a standard tool used for the appraisal and the appraisal report is filed electronically in the staff member's personal file. The appraisal encompasses professional development and educational needs. Ongoing training and education in quality and safety is addressed in the annual mandatory training program, and the quality management orientation teleconference series provided by Healthscope head office.

Feedback from staff members is gained via the staff satisfaction surveys, staff tool box meetings, staff forums, and the medical officer satisfaction surveys.

Incident and complaints management

HVPH has effective systems in place to report and manage incidents and complaints. A robust reporting culture is noted through steadily increasing reportings. Incidents, complaints and near misses (all of which are very few in number) are rigorously investigated and action plans developed and monitored where system improvement is required. All incidents are entered into the RiskMan database. The Healthscope Board being the highest level of governance is made aware of all serious incidents and complaints, and aggregated data related to low level incidents is provided and reviewed. All response timeframes meet or exceed Healthscope performance requirements.

Consumer feedback is actively encouraged and numerous mechanisms, including formal surveys, the Ministerial complaints system and letters to the organisation are carefully considered. Many examples of resulting improvements were provided.

An open disclosure program is in place that is consistent with the national open disclosure standard. All clinical staff are appropriately trained. It is suggested that serious incident review documents contain reference to whether open disclosure has occurred. This would assist in monitoring the effectiveness of the program.

Accurate, integrated patient clinical records are available at the point of care and readily accessible to staff. Confidentiality is maintained. Clinical records are designed to accommodate audit requirements, and appropriate auditing of records occurs.

Patient rights and engagement

Information relating to patient rights and responsibilities consistent with the current National Charter, is provided to all patients via the Healthscope website and in admission packages. If a patient is at risk of not being able to understand, the information is explained verbally or through the use of an interpreter, to carers and family members if cognitive impairment is an issue. The Consumer Consultant seeks feedback from patients relating to their understanding of their rights and reports issues of concern to the management team if they are raised.

The survey team noted that patients and carers are now supported to document clear advance care directives and/or treatment limiting orders with the electronic Alert system identifying patients where such a directive, or a treatment limiting document has been produced.

Patient clinical records are available at the point of care. Relevant policies and procedures support staff to ensure privacy and confidentiality of patient information.

There are systems and processes to obtain patient and carer feedback on the care and services provided that include involvement of consumers and several examples were provided of this.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Hunter Valley Private Hospital (HVPH) has made great strides since the previous survey in relation to how it partners with consumers. Having made a strategic decision to more fully engage with consumers at both corporate and hospital level, support is now readily available for hospitals to meet their objectives via the Healthscope Consumer Participation Cluster. Mechanisms for the participation of consumers in designing and redesigning care are established and community input into the development of new facilities is acknowledged in service design and development documents.

Corporate Consumer Consultants advise the Healthscope executive on strategic matters relating to the Standard, while at HVPH the Consumer Consultant performs this role at local level.

Consumers engaging with the hospital are actively canvassed for expressions of interest in partnering the hospital as Consumer Consultants and several have agreed to participate in the program either as consultants or on focus groups. Training for consumer representatives is available and the HVPH Consumer Consultant was formally oriented to her role and to the organisation on commencement. More training is planned for consumers who are shortly to partner the organisation.

Evidence was available demonstrating that consumer representatives have been consulted in the development and revision of all relevant corporate publications/patient information materials and that feedback has been incorporated in the documentation.

Consumer partnership in designing care

Corporate Consumer consultants partner Healthscope Pty Ltd in designing care in a strategic sense, whilst at local level, the HVPH Consumer Consultant provides meaningful input into how care is provided. She was able to provide surveyors with many examples of how her contributions have made a positive difference to patient care.

Person centred care is incorporated into the education process and mapped to the Standards. It is part of the orientation program for all Healthscope hospitals and teaches how care impacts on the patient experience and outcomes.

High rates of training in patient-centred care are noted for clinical leaders, senior managers and the workforce. The Consumer Consultant assists in training the workforce through a regular presentation at orientation, and opportunistic face-to-face training in the ward areas. The patient experience is also featured through a range of corporate videos aimed at reinforcing patient centred care.

Consumer partnership in service measurement and evaluation

The HPVH Consumer Consultant is an active member of the hospital Quality and Safety Committee, participating fully in the analysis of organisational safety and quality performance. She provides feedback from a consumer perspective and assists in the creation and monitoring of action plans which meet consumer expectations as well as those of the organisation.

It is also within the remit of the HVPH Consumer Consultant to participate in the evaluation of evaluating patient feedback data and implementing quality improvements. Several examples were provided in this regard.

The MyHealthscope website also comprehensively displays trended, benchmarked safety and quality data for all hospitals in its fleet ensuring that the wider public has access to reliable clinical information, and can thus make meaningful decisions about their healthcare.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Hunter Valley Private Hospital (HVPH) is maturing in its approach to infection prevention and control. There is a comprehensive infection control (IC) framework comprising policies supported by local procedures, a small but active Infection Prevention Committee (IPC) with expert medical input, and clear reporting lines through the hospital's Safety and Quality Committee to the Executive team and Healthscope Board which requires rigorous monitoring of several key performance indicators (KPIs) relating to infection control. Whilst the IPC has clear terms of reference and is well managed it is suggested that the organisation reviews the roles of Chair and secretariat to optimise the Committee's effectiveness.

The framework is informed by an expert external provider which also oversees the IC risk management process through a biennial risk assessment program and the conduct of an extensive gap analysis regarding AS4187-14. The system is compliant with the Australian Guidelines for Infection Control and evidence-based (and/or best practice). The private IC consultancy company ensures policies are current and monitors compliance with their use. An information sharing electronic newsletter delivers updated infection control information to all staff. Policies and guidelines are comprehensive, easily accessed and regularly reviewed. At survey, there was evidence of a satisfactory level of understanding of infection prevention and control by clinical staff, and policies and guidelines appeared to be well utilised. Advice is sought as required from a local microbiologist, the private provider or through the Healthscope Infection Control Cluster, comprised of all infection control coordinators throughout Healthscope hospitals and the source of valuable support and information to the newly appointed IC nurse at HPVH.

Reporting of a relevant range of key performance indicators (including infection surveillance outcomes) occurs at the highest level of governance, and the framework is regularly reviewed by the organisation. Infection rates are very low. A system is in place to take appropriate action in the event that a rate change is observed.

A quality improvement program is in place to prevent and minimise hospital acquired infections with a number of initiatives incorporated into the infection prevention and management plan. Liaison nurses in each ward assist the IC nurse to meet the organisation's infection prevention and control goals.

An antimicrobial stewardship program is also in place, contributing to the governance process.

Infection prevention and control strategies

The Hand Hygiene program is in evidence with posters, hand hygiene stations and cleansing product readily available throughout the hospital. Hand Hygiene audit outcomes demonstrate ongoing improvement with recent rates exceeding 83%, which is not quite at the level of the Healthscope benchmark, though exceeds that of Hand Hygiene Australia's at 80%. Despite these good results the organisation should not be complacent, with ongoing efforts to keep the rate at or above this level essential, particularly in regard to medical practitioners, where the rates are much lower.

A workforce immunisation program compliant with national guidelines is in place and immunisation rates are adequate, particularly for new staff who cannot commence employment without completing the required program. A database managing this is in place and is under review. An influenza vaccination program is in place with many of the hospitals' employees electing to be vaccinated. Exposures to blood and body fluids are well managed, and the appropriate use of personal protective equipment was noted throughout the facility. A system is in place to ensure that staff with occupational sensitivities are identified and appropriately managed.

A lot of education is available to staff about infection prevention and control. Staff are mandated to undertake on-line infection control training and rates of completion have recently improved significantly. Many relevant clinical staff have been trained and assessed as competent in aseptic technique (thereby meeting the requirements of the applicable action under transitional arrangements) and education in the management of invasive devices meets established targets.

Managing patients with infections or colonisations

Standard precautions were in evidence and transmission-based precautions consistent with national guidelines were observed to be in use. Management of infectious patients focuses on early detection and appropriate segregation (usually in single rooms) with transmission-based precautions. Systems are in place to identify or communicate potentially infectious patients, including identification as an alert in the patient management system. There is a requirement for such information to be transferred to the Alert Sheet at the front of the patient record so that bedside staff are aware of a patient's infectious status. Use of the Alert Sheet was noted to be steadily improving. Information about patients' infectious status is sought before admission through pre-admission processes where possible. Questions regarding infectious status form part of routine systems when transferring to and from the organisation; and situations where information has been omitted or incorrectly conveyed are reported and analysed through the incident management system. Patients transferring from other hospitals are routinely swabbed and segregated until infectious status has been established if unknown prior.

Antimicrobial stewardship

HVPH has an adequate antimicrobial stewardship (AMS) program overseen by the Drug and Therapeutics Committee and well supported by an enthusiastic and knowledgeable Pharmacist. A Microbiologist from a nearby tertiary hospital is readily available for advice. Relevant activities and audit outcomes are reported to the Infection Prevention Committee, and the Drugs and Therapeutics Committee for decisions of a therapeutic nature. Restricted antimicrobials are controlled by an authorisation mechanism. The pharmacist provides ongoing education to individual clinicians and compliance with the relevant Therapeutic Guidelines is high. The surveyors encourage the organisation to continue and strengthen its endeavours regarding antimicrobial stewardship and to improve its surveillance of surgical prophylaxis in line with the recently issued Advisory from the ACSQHC A17/01.

Cleaning, disinfection and sterilisation

Appropriate systems of control, including a comprehensive suite of policies and protocols, are in place regarding cleaning, disinfection and sterilisation. Comprehensive education, work instructions and cleaning schedules are evident, including management of clean and soiled linen, which is processed on site.

Similarly, the hydrotherapy pool is well maintained and compliant with IC policy.

Cleaning products are well managed and hard copy material safety data (MSD) sheets are readily available.

The hospital presented as very clean and tidy and there was evidence of a high standard of compliance with the hospital's cleaning program.

A comprehensive gap analysis has been conducted by an expert external provider regarding AS 4187 – 14 and the organisation is currently 75% compliant with the recommendations made. Outstanding requirements relate to capital expenditure for which Healthscope corporate has assumed responsibility. HVPH is well advanced with its implementation plan; the organisation continues to work towards meeting its obligations relating to cleaning, disinfection and sterilisation.

Communicating with patients and carers

Across the organisation information for patients and carers on infection prevention and management is available and visible, including in bedside compendium. There was little evidence of infection control audit outcomes such as hand hygiene audit results are on public display on performance boards in any ward areas, for either staff or patients/visitors to observe and this could improve. Patients however are encouraged, and reminded with visual prompts, about the importance of hand hygiene.

Transmission-based precautions signage is prominent and in plain language, with individual education provided to affected patients and carers.

All information provided to patients and carers to ensure that it meets the needs of its target population has been vetted by consumers and evaluated for its effectiveness.

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

Eighty-two percent (82%) of the clinical workforce is trained in aseptic technique, the action thereby complying with transitional arrangements for 2018.

Surveyor's Recommendation:

No recommendation

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

An AS4197-14 gap analysis and plan has been undertaken and is 75% implemented. Outstanding items are largely capital expenditure/infrastructure related and are being managed at corporate level.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Governance for medication safety is embedded in a cluster medication safety committee and a HVPH local committee - the Drug and Therapeutics Committee. The local committee comprises a medical officer, the pharmacist, the Director of Nursing and the nurse unit managers meeting on a quarterly basis. Policies and procedures are in place based on both Healthscope and Slade Pharmacy policies. Compliance is measured and audited. Legislative requirements are met and a recent quality action has been to ensure that phone orders for medication are sighed by the medical officers within the required time limits. The medication management system is reviewed on a regular three-monthly basis by the Healthscope cluster committee. Actions to improve the system are triggered by the KPI reporting, the committee reviews, and by the shared learning from other facilities. The results of patient satisfaction surveys indicate that the system is suitable for meeting the patient's needs. In regard to authorised prescribers, the HVPH utilises the pre-printed Medicare endorsed medication charts that require the prescribing doctor to record his/her prescribing number in the chart against each medication. This is monitored by the pharmacist. The surveyors noted the high quality of the services provided to the hospital by the Contracted pharmacy unit.

Medication incidents are recorded in RiskMan. Incidents may be entered by the clinical staff and by the pharmacy staff members. The analysis of the RiskMan data reveals that he most common issues reported (or perhaps over reported) are missed medications, prescriber not indicating if a sustained form of the medication is required, and the persons administering the medications have not correctly signed the chart. Adverse medication incidents have not occurred. This is the result of the actions routinely taken by the pharmacy service, the oversight of the governance structure, and the use of a risk management approach to medication safety. Medication bulletins are provided to the staff form the pharmacy service, medication safety alerts are also provided and education sessions are provided by the pharmacy. Quality improvements include auditing with the NIMC equivalent, the use of approved labels for intravenous medications, safety control of the storage of potassium ampoules and the use of Tall man lettering.

Documentation of patient information

A medication history is gained at preadmission and at time of admission. This is reconciled by the nursing staff and assistance is sought from the pharmacist in complex cases. The history is recorded in the medication chart. The chart is available in the ward situation and also follows the patient on transfer to theatres and radiology. Known medication allergies are recorded in the medication chart and are also recorded on an Alert sheet placed at the front of the medial record. The compliance with recording the know allergies is audited and reveals excellent compliance. Medications are documented and reconciled at time of transfer to another facility.

Medication management processes

Information and decision support tools are readily available to the clinical staff. These include e-Therapeutic Guidelines, eMIMS, the Australian Medicine Handbook, the Don't Rush to Crush book and the Injectable Drugs book. It is noted that the most frequent source of advice is direct contact with the pharmacist. Risks associated with the storage of the medicines met the requirements for Schedule 4 and 8 medications. During the survey improved locking systems were commissioned for the medication rooms. The procedures for distribution of medications are safe and the risk register included the risk management of drug storage. Actions taken to reduce storage risks include pharmacy control over new products and drug delivery devices, bar coding of medications in storage areas, regular review of stock lists, and pharmacy management of the out-of-hours medication cupboard. Patient's medications brought in from home at time of admission are safely stored within the ward environment.

At time of discharge the medications are reviewed by the pharmacist. Temperature sensitive medications are stored in refrigerators that are temperature monitored.

The Scheduled Drug registers are kept in a secure manner and include the recording of the disposal of unused drugs. High risk medications are not part of the ward impress systems and are not in common use at the hospital. The pharmacist manages the storage of such medicines if they are to be administered. The hospital does not currently utilise "smart" infusion pumps but the purchase of these is under consideration.

Continuity of medication management

The hospital pharmacy is able to generate a list of medications being prescribed to the inpatients. This is in conjunction with the medication chart listing. At time of handover, the patient's medication chart is used to inform staff of the current therapeutic regimes. A list of medications and information about the medications is provided to the patients at time of discharge from hospital. The pharmacist is the provider of the information and provides written information as required.

Communicating with patients and carers

Medication information for patients is available and is usually provided in person by the pharmacist. This information is also available to the clinical staff members. A Medication management plan is prepared and documented in the medication chart prior to discharge. The pharmacist oversights the finalisation of the management plans. Patient surveys indicate that the vast majority of patients are satisfied with the medication management services they receive and find the information appropriate and helpful.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The hospital has policies and procedures in place to govern patient identification and procedure matching. Patient identification is based on three identifiers, being name, date of birth and medical record number. Address is also used as a supplementary ID parameter. Audits of the system are carried out and include the correct patient ID band, time out in procedural areas, orderly transport name checks, and patient consent to procedures. Improvements are undertaken when the audits show the opportunity for improvement such as additional education for the orderlies in checking patients names when requested to move a patient from one area to another. Any mismatches in patient ID and procedure matching is reported in the RiskMan system. There are also KPIs relating to effective patient ID procedure compliance. Recent audits (October 2017) indicate good compliance with the policies.

Processes to transfer care

Patient ID is an essential part of the handover process and the checking of the ID is recorded in the handover of medical records. Survey team members noted that the hospital is placing emphasis on patient identification via handover training videos and in the use of staff lanyard card tags which contain prompts for effective handover.

Processes to match patients and their care

Patient procedure matching in the form of 'time out' takes place in the operating rooms, prior to blood administration and prior to medication administration. A record of the time out in the procedural areas is made and kept in the patient's medical record. Monitoring of the processes is undertaken with an annual patient ID audit, the regular critical systems review and the application of an RCA in the occurrence of a mismatching event. Improvements are gained by action plans, further targeted education, and committee reviews of incidents.

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

The policies and procedures for clinical handover are based on the Healthscope national guidelines and policies. At ward level both face-to-face and bedside hand overs take place. The compliance with the hand over procedures is monitored and audited on a monthly basis. Effectiveness is maximised by regular staff education. The current hand over tool is MiSHARED. However, it is noted that the hospital is currently assessing the advantages of changing to the ISBAR tool for clinical hand over.

Clinical handover processes

There are checklists for specific handover occasions such as the procedural safety checklist, the surgical safety checklist, the pre-op and post-op safety checklist, and the policy for consent. As part of the preparation for ward hand over, a MiSHARED printout of the patients from the handover is obtained. At ward level there is one bedside hand over each day and two face-to-face hand overs by staff face-to- face meetings. Monitoring of the processes is undertaken by observational audits, monthly formal record audits and annual documentation audits. Staff involvement and patient involvement is reviewed at staff meetings, staff surveys, ward meetings, and RiskMan reports. The effectiveness of the system is reviewed at the local level by the Quality Committee and the quarterly Executive review. At a national level the review data is sent to the national clinical risk manager, and the Comprehensive Care Cluster of Healthscope.

All incidents relating to handover are reported via RiskMan, and there are KPIs for the regular auditing and reporting against the systems. Risk reduction is encompassed via the Shared Learning program and by the assessment and actions of the Quality committee and the MAC.

Patient and carer involvement in clinical handover

There is a bed side compendium that provides information for the patients about handover. Information on the intranet is also available to all staff members. Patient care surveys reflect the level of patient involvement being sought. The survey team noted the particular emphasis the hospital was now placing on patient involvement in the handover process and that this is emphasis in the training video and the staff tags on handover.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

The blood and blood product policies and procedures in place at the HVPH are consistent with the national guidelines, and with the Healthscope national policies and procedures. Modification of the procedures has taken place to reflect the nature and level of service required at the HVPH. Governance systems include the Healthscope cluster committee that is attended by HVPH, the local hospital Transfusion committee that includes on its membership the blood bank supplier, and the appointment of a local champion at the hospital being a member of the senior nursing staff. There is a suite of audits and KPIs in place that are reported to and assessed by the governance committees. There is also benchmarking in place that indicated HVPH is meeting the expected outcomes in a satisfactory manner. Recent actions to increase safety include the introduction of the new Blood product guidelines form by the Red Cross, and the utilisation of ‘Flip Boards' that provide information to staff members about transfusion issues. The audit process is used to regularly assess the risks associated with transfusion practices.

Incidents relating to blood and blood product services are reported via RiskMan. Transfusion risks are also included in the risk register. Adverse blood incidents are also reported via RiskMan and are reported to the Quality Committee and the Medical Advisory Committee. Quality improvements have included the preparation and distribution of the folder for the clinical areas that provided the information, data and references for a staff member about how to manage a transfusion.

Documenting patient information

A patient's blood transfusion history is captured on the specific blood transfusion form called the Blood and Blood products prescription and transfusion record. This form is part of the patient's medical record. Audits of the completion of the record are carried out on a regular basis. Adverse blood reactions are recorded in the blood transfusion sheets that are part of the medical record. The champion reviews the audit results and then undertakes actions to reduce any identified compliance gaps. Adverse events are reported internally to the quality committee and to the medical advisory committee. There is an active liaison with the blood service provider who is an established pathology organisation. Adverse events are also reported to the corporate quality governance.

The survey team noted the enthusiasm and commitment of the local champion, and suggested that the hospital may wish to set up an arrangement that a set number of members of the nursing staff undertake all elective transfusions.

Managing blood and blood product safety

The HVPH 'blood transfusion champion’ ensures that the appropriate audits are undertaken and completed, that the register of the blood and blood products is up-to-date, and carries out observational audits for venesection tube identification when blood is collected for group and hold venesection. Recent quality activities include ensuring staff members complete their blood safe training, and the use of specific insulated containers to transport blood packs around the hospital. Blood wastage is monitored and there have been no recorded incidents of wastage occurring.

Communicating with patients and carers

Clinical staff members record in the medical record when they have provided written information to the patients prior to the commencement of a transfusion. There are patient brochures that provide such information for the patients. Also, there are posters in the clinical areas providing information about blood services. These brochures and poster originate from "Transfusion.com." internet services. Transfusion plans are prepared in conjunction with the patient and their treating medical officer. Informed consent by the patient is gained by the medical officer and recorded in the medical record.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Pressure injury prevention and management at Hunter Valley Private Hospital (HVPH) is overseen by the Standard 8 Committee, a small but committed team which reports its audit results and incident outcomes to the Executive Quality and Safety Committee for consideration, and to the Healthscope Board via robust clinical key performance indicators (KPI). Representation on the Committee includes infection control, wound management and nutrition expertise to ensure a comprehensive approach to skin integrity.

Policies and procedures in use are consistent with the most recent evidence-based guidelines and compliance with their use is monitored. Support for pressure injury prevention and management is provided by the Healthscope Pressure Injury Cluster, a collaborative of experts within the Healthscope system.

RiskMan, an electronic incident management database is used as HVPH's system for reporting pressure injuries which allows data to be aggregated and trended. Hospital acquired pressure injuries are negligible and always low in severity. The few more serious injuries that the organisation identifies and manages are almost always either community acquired or acquired at another facility.

Multiple strategies have been implemented across the area to reduce the frequency and severity of pressure injuries and to improve pressure injury management. These include early screening and assessment; improved nutrition management, and the early introduction of pressure relieving devices. Patients in the Operating Theatre are similarly assessed and in long cases pressure area care is implemented and documented.

Preventing pressure injuries

Until October 2017 HVPH used the Braden Scale to risk manage patients attending the hospital, switching recently to the Waterlow score to make it consistent with all other Healthscope facilities. Staff are still learning the new screening and assessment processes but close attention to comprehensive documentation completion has had excellent results and audits demonstrate very high compliance, born out by chart reviews by surveyors at survey.

Similarly, skin inspections were undertaken and documented in every instance.

Prevention plans form part of the suite of documents and are completed in collaboration with patients or their carers. Recent audits identify high levels of compliance with completing the prevention plan appropriately and accurately.

The diligence of the Standard 8 Committee is reflected in these results.

Managing pressure injuries

An evidence-based wound management system is in place and overseen by the Medical Ward Nurse Manager, (an expert in this area) who also supervises management plans for all patients with pressure injuries.

Management plans are documented in the clinical record. The Nurse Manager also liaises with Visiting Medical Officers (VMOs) to ensure that best practice management and dressings are prescribed. Referrals are made to appropriate experts including dietitians, to ensure care is comprehensive.

Records are monitored for compliance with the management plan, and with best practice principles. Any deviations from the planned path are discussed with individual staff. All audit outcomes are reviewed and addressed by the Standard 8 Committee.

Effective systems are in place to ensure appropriate transfer of care to the community or other healthcare facilities.

Communicating with patients and carers

Patients and/or carers receive considerable information regarding pressure injury prevention. Key messages are included in the consumer information booklet provided to each patient. Volunteers have established, via questionnaires and talking with patients, that such information is meaningful and easy to understand.

Pressure injury prevention plans are completed in collaboration with patients or their carers.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

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

The governance for management of a deteriorating patient process is firstly at the Healthscope regional level with a cluster committee for the management of a deteriorating patient. This committee has recently been renamed the Comprehensive Care Committee. Within the HVPH both the Quality Committee and the Medical Advisory Committee are also involved in governance of these policies and procedures. There is a champion on the staff who attends the committees at both local and regional levels. Policies and procedures are kept up-to-date by this governance mechanism. Feedback from the clinical staff members is gained from the medical advisory committee, the RiskMan reporting system, and the reviews carried out after a call out has occurred.

All unexpected deaths or cardiac arrests are subject of review by medical peers. The outcome of the review is forwarded to the medical advisory committee and the hospital executive. It is noted that there have been no deaths in the surgical service in recent times. Actions taken or being taken to improve the effectiveness of the system includes more Advanced Life Support training for staff members, Paediatric ALS courses to be undertaken, and an annual refresher course to be continued to maintain staff members skills.

Recognising clinical deterioration and escalating care

The hospital has observation charts that are based on the national chart. These are colour coded records with the trigger points for seeking help clearly displayed. Also on the chart is the pathway for a staff member to follow for escalating care. There is one adult chart and three age related charts for children. There is an annual audit of the charts to measure the rate of completion of the chart. All patients are noted to have a chart. The full completion of the chart is in the range of above 80 per cent. The hospital is about to introduce the new Healthscope national observation chart. The introduction will be accompanied by staff education.

The call out systems have three levels - a patient call system that is connected to the nurse call system, a nurse call system for the use of nursing staff members, and a red emergency button for triggering a full emergency response. The response systems are reviewed on each occasion they are triggered and there is an audit of "failure to trigger" events. Reviews of the call out system have not recently demonstrated any significant issues.

Responding to clinical deterioration

The criteria for triggering an escalation response is clearly outlined on the observation chart and are in line with national conventions. The circumstances of all escalations are reviewed by the quality committee and the medical advisory committee.

All clinical staff members are trained on an annual basis in basic life support. Members of the nursing staff that have supervisory roles are also trained in advanced life support. Recently, an additional six members of the nursing staff undertook ALS training. In weekday daytime hours, there are medical staff on site, including CMOs and often an anaesthetist.

Communicating with patients and carers

Patients and carers are informed about speaking up to staff about any concerns that they have, and are also informed about the escalation processes and call out mechanisms. If a patient has an advanced care plan, a copy of the plan is placed in the medical record. Assistance is provided for patients seeking to draw up a plan. Treatment limiting orders are recorded in the medical record and are verified if the patient is transferred in from another facility.

Patients and carers are informed about the mechanisms available to them to initiate an escalation of care. Information is provided at each bed side. These patient-initiated call outs have been very infrequent. No issues have been identified to further improve this system.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

All clinical staff members of HVPH undertake annual training in basic life support. This action is fully met.

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

Hunter Valley Private Hospital (HVPH) has a frail, elderly primary population and takes prevention of falls very seriously. The falls prevention system is governed at local level by the highly motivated and enthusiastic Falls Prevention Committee, a multidisciplinary committee with wide representation across the organisation which reports to the organisation's Safety and Quality Committee, and executive oversight occurs at Healthscope Board level via robust clinical key performance indicators (KPI).

Support for falls prevention is provided by the Healthscope Falls Prevention Cluster, a collaborative of experts within the Healthscope system which also develops, and monitors falls prevention policy.

HPVH now uses RiskMan, an electronic incident management database that is used as its system for reporting falls, which allows data to be aggregated and trended. Each incident is individually reviewed and action plans are developed to reduce risks as required.

The organisation has a very comprehensive cluster of strategies in place to reduce risks from falls. These include early identification of patients at increased risk of harm from falling; mechanisms for identifying falls risk patients; pressure sensitive mats to alert staff to a patient attempting to get out of bed; and regular rounding, particularly frequent for patients at high risk of falling.

Despite close attention, the number of falls is significant and HPVH is an outlier when benchmarked against its peer hospitals within Healthscope.

Screening and assessing risks of falls and harm from falling

A best practice Falls screening and assessment tool (FRAT) is in use, and compliance with its accurate and comprehensive completion is very high amongst staff as identified via regular audit, and observed by surveyors at time of survey. Through the screening process patients at high risk of falling are all appropriately identified in a timely manner.

The Falls Prevention Committee is active in keeping screening/assessment documentation rates at very high levels.

Preventing falls and harm from falling

HVPH is fully committed to minimising risks associated with falls and resultant harm. Prevention plans form part of the suite of documents and are completed in collaboration with patients or their carers. Recent audits identify significant increases in compliance with completing the prevention plan.

Additional improvement strategies include the purchase of additional falls prevention equipment such as pressure mats and motion sensors and environmental monitoring. A recent review found that most falls occur when patients try to go to the toilet unaccompanied, despite the fact that purposeful rounding takes place at hourly intervals. Sometimes the frequency of rounding is increased to thirty minutely if a patient is at particularly high risk and in some instances, patients are 'specialed' to avoid attempts to get out of bed without assistance. Surveyors suggest that as part of rounding, high risk patients are assisted to the toilet rather than staff relying on a patient's response in the negative to questions about wanting to go to the toilet.

All complex patients who are at risk of falling undergo comprehensive, multidisciplinary discharge planning in order to safely transfer care via referral to appropriate outpatient or community services.

Communicating with patients and carers

Patients and/or carers receive considerable information in regard to falls prevention. Key messages are included in the consumer information booklet provided to each patient. Volunteers have established, via questionnaires and talking with patients, that such information is meaningful and easy to understand.

April Falls Week highlights the risks associated with falling and prevention strategies.

Falls prevention plans are completed in collaboration with patients or their carers; and form part of discharge planning for ongoing care.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

patient harm and increase the quality and effectiveness of medicines use

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in	SM	SM

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

Processes to transfer care

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

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Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

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Blood and Blood Products

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

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

Documenting patient information

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

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage,	SM	SM

	collection and transport of blood and blood products is undertaken		
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on	SM	SM

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition	SM	SM

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance	SM	SM

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	are regularly reviewed		
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	SM	SM

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Recommendations from Current Survey

Nil

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 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

Recommendation: EN OWS 0615.1.4.3

Recommendation:

Review all information provided to locum doctors and agency nurses for orientation to the workplace and to ensure knowledge of their safety and quality roles and responsibilities.

Action:

HVPH has developed a facility induction that is provided to the nursing agencies for staff to attend and then on the day of their shift they receive a ward orientation. HCA and other agencies have a register of staff that have attended HVPH. This package is planned to be distributed to the nursing agencies by the end of March 2018.

Completion Due By: 31.03.2018

Responsibility: DDON

Organisation Completed: No

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

Strategies are now in place ensuring doctors and agency staff undergo orientation to the workplace, including their roles and responsibilities relating to quality and safety.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Patient rights and engagement
Action: 1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders

Recommendation: EN OWS 0615.1.18.4

Recommendation:

Support patients and their carers in completing advance care directives and treatment limiting orders through providing information and, where necessary, assistance in documenting clear advance care directives and/or treatment limiting orders.

Action:

Implementation of the MOLST form into all areas which is being used. HSO HMR000 Alert Sheet utilized at HVPH to document Advanced Care Directives and treatment limiting orders.

Patients are prompted about having an advanced care directive during their admission and requested to provide a copy of advance care directives if they have one on admission to hospital.

Completion Due By: 31/12/2016

Responsibility: DON

Organisation Completed: Yes

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

The MOLST tool, which records patient/family wishes relating to treatment limitation is now used in all inpatient areas. A process is in place relating to documentation of advance care directives.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.1.1 Consumers and/or carers are involved in the governance of the health service organisation

Recommendation: EN OWS 0615.2.1.1

Recommendation:

Develop a consumer engagement strategy that Identifies and implements a mechanism for involving consumers and/or carers in the governance of the health service.

Action:

Consumer representative will be inducted and become part of our quality committee where all quality projects and audit results are discussed and strategies to improve are developed.

As part of Healthscope a consumer representative sits on the head office governance meetings.

Completion Due By: 30/9/16

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy which involves consumers and/or carers in the governance of the health service has now been implemented, occurring at both corporate and local level as appropriate.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 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

Recommendation: EN OWS 0615.2.1.2

Recommendation:

The organisation identify the range of backgrounds represented by the population served and undertake an analysis to identify groups to represent patient and community groups served by the health service.

Action:

All members of the focus group (4 people) were asked to become long term partners with the hospital and they were willing.

Most populations are represented with patients post rehab, day rehab, surgical, same day surgical and medical patients.

Consumers roles are also developing and we hope to introduce them to patients during our patient survey periods.

Completion Due By: 30/12/2017

Responsibility: DON

Organisation Completed: Yes

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

The organisation has identified the range of backgrounds represented by the population served and undertaken an analysis to identify groups to represent patient and community groups served by the health service. Representation from all areas occurs on consumer focus groups run by the organisation, with a growing pool of interested consumers.

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

Recommendation: EN OWS 0615.2.2.1

Recommendation:

Develop a consumer engagement strategy that Identifies and implements mechanisms for involving consumers and/or carers in strategic and operational planning.

Action:

Quality strategic plan which feeds into the hospital and corporate strategic plans is completed during the meeting which will have a consumer representative allowing for input into it.

Completion Due By: 30/090/2017

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy has been developed that identifies and implements mechanisms for involving consumers and/or carers in strategic and operational planning. This now occurs at corporate level and at local level.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality

Recommendation: EN OWS 0615.2.2.2

Recommendation:

Develop a consumer engagement strategy that Identifies strategies, methods of consumer involvement and level of engagement for consumers and carers in decision making about safety and quality.

Action:

Present at the quality meeting will ensure this information is provided to our consumers rep.

This will commence in January 2017 after the rep has been given education regarding their involvement.

Consumers cluster from Healthscope has been a great way to see how others are involving consumers.

Completion Due By: 30/9/16

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy that identifies strategies, methods of consumer involvement and level of engagement for consumers and carers in decision making about safety and quality is now in place. The consumer consultant was able to describe numerous examples of where her input has been acknowledged by the organisation, and where resultant changes have occurred.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role

Recommendation: EN OWS 0615.2.3.1

Recommendation:

Develop a consumer engagement strategy that Identifies and implements a training program for consumer and/or carer roles when they are engaging at a governance, planning and safety and quality decision making level.

Action:

As part of Healthscope all consumer induction and orientation programs are available and will be used during a consumer focus group planned for August.

Completion Due By: 24/8/16

Responsibility: Educator

Organisation Completed: Yes

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

A consumer engagement strategy that identifies and implements a training program for consumer and/or carer roles when they are engaging at a governance, planning and safety and quality decision making level is now in place. The consumer consultant was able to describe her training to surveyors at survey. Additional consumer representatives being recruited will undergo training as they are inducted into the organisation.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.5.1 Consumers and/or carers participate in the design and redesign of health services

Recommendation: EN OWS 0615.2.5.1

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the design and redesign of the health service.

Action:

During focus group meetings the future of the hospital is discussed and future plans for changes/additions will be discussed with this group of consumers.

Consumers also offer feedback when returning as patients and have been involved in the redesign of the day only program.

Completion Due By: 1/6/17

Responsibility: DON

Organisation Completed: Yes

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

A system is now in place for the involving of consumers and/or carers in the design and redesign of the health service. The consumer consultant was able to provide examples of how this has occurred at Hunter Valley Private Hospital.

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

Recommendation: EN OWS 0615.2.6.2

Recommendation:

Identify key areas/specialties where consumers are able to provide training to clinical staff. Consider the use of consumers in orientation of staff.

Action:

Being part of Healthscope consumer cluster has given us many strategies that we can implement to have consumers involved in the education.

One area of focus for our educator is coordinating the training from consumer to staff in improve care outcomes. Our consumer representative has a session at our staff orientation to educate new staff on their role and perspective.

Completion Due By: 31/12/2017

Responsibility: Educator

Organisation Completed: Yes

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

The consumer consultant was able to provide examples of training she provided to clinical staff, including at orientation. She also conducts opportunistic training to individual staff in the ward environment.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance

Recommendation: EN OWS 0615.2.8.1

Recommendation:

Develop a consumer engagement strategy that Identifies organisational safety and quality data and mechanisms to engage consumers and carers in the analysis of the health service's safety and quality performance.

Action:

Consumer will sit on the quality committee where all safety and quality data is tabled and benchmarks and strategies to improve are discussed.

Completion Due By: 30/9/16

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy that identifies organisational safety and quality data and mechanisms to engage consumers and carers in the analysis of the health service's safety and quality performance is now in place. The consumer consultant was able to demonstrate to surveyors that she is a valued member of the organisation's Quality and Safety Committee which has overseen the implementation of many of her suggestions in regard to improving quality of care.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Recommendation: EN OWS 0615.2.8.2

Recommendation:

Develop a consumer engagement strategy that Identifies a range of ways for consumers to be involved in the health service including the planning and implementation of quality improvements.

Action:

Sitting on the quality committee will provide input into quality improvement activities and increase awareness to committee members of benefits of consumer input.

Day only rehab program has had consumer involvement in its redesign.

Completion Due By: 31/12/16

Responsibility: Quality Committee

Organisation Completed: Yes

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

A consumer engagement strategy that identifies a range of ways for consumers to be involved in the health service including the planning and implementation of quality improvements is now in place. The consumer consultant was able to articulate her role in this process. Other interested consumers are being recruited to expand the existing service.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data

Recommendation: EN OWS 0615.2.9.1

Recommendation:

Develop a consumer engagement strategy that Identifies and implements a mechanism to enable consumers and carers to participate in the evaluation of patient feedback data.

Action:

Involvement on quality committee and the biannual focus group meetings will increase exposure as will submission of data to the MyHospital and MyHealthscope websites.

Completion Due By: 30/09/2016

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy that identifies and implements a mechanism to enable consumers and carers to participate in the evaluation of patient feedback data is now in place. The consumer consultant provided evidence of how this occurs.

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

Recommendation: EN OWS 0615.2.9.2

Recommendation:

Develop a consumer engagement strategy that Identifies and implements a mechanism to enable consumers and carers to participate in the implementation of quality activities relating to patient feedback data.

Action:

Surveys are completed via HSO format every quarter across all areas and this data will be discussed at quality meetings where a consumer is present and involved in the strategies to improve.

Completion Due By: 30/09/2016

Responsibility: DON

Organisation Completed: Yes

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

A consumer engagement strategy that identifies and implements a mechanism to enable consumers and carers to participate in the implementation of quality activities relating to patient feedback data is now in place. The consumer consultant was able to articulate her role in this process.

Standard: Preventing and Managing Pressure Injuries
Criterion: Preventing pressure injuries
Action: 8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan

Recommendation: EN OWS 0615.8.7.3

Recommendation:

Monitor patient clinical records to identify the proportion of at-risk patients that have evidence of an implemented pressure injury prevention plan.

Action:

Audits are undertaken and if benchmark is not reached action plan completed and re-audit attended.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

Patient clinical records to identify the proportion of at-risk patients that have evidence of an implemented pressure injury prevention plan are now regularly monitored with results showing high compliance with policy in this regard.

Standard: Preventing and Managing Pressure Injuries
Criterion: Preventing pressure injuries
Action: 8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan

Recommendation: EN OWS 0615.8.7.4

Recommendation:

Ensure that action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan.

Action:

All at risk patients have a comprehensive skin assessment on admission and a pressure injury risk assessment (Braden) completed with interventions identified and implemented accordingly. Audited as per HSO Quality KPI schedule and clinical indicators reported quarterly to HSO and biannually to ACHS clinical indicators.

Completion Due By: 31/12/2016

Responsibility: DON

Organisation Completed: Yes

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

A range of actions has been implemented to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan. Audits demonstrate steadily increasing compliance in this regard with surveyors noting full compliance during record review at survey.

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Combined

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

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

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Surveyor - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : Hunter Valley Private Hospital
Orgcode : 120308

Combined

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

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