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

John Fawkner Private Hospital

Coburg, VIC

Organisation Code: 22 01 89

Survey Date: 19-21 March 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 organisations accreditation survey. This report is divided into five main sections.

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Survey Report

Survey Overview

John Fawkner Private Hospital (JFPH) is owned and operated by Healthscope Ltd (HSP). It is registered with the Department of Health and Human Services in the state of Victoria as a 147 bed hospital. The hospital commenced operations in 1939 under the auspice of the Missionary Sisters of the Sacred Heart and maintains this favourable reputation across the community that it serves.

JFPH is undergoing a significant refurbishment and extension and at survey the main hospital block was a building site in part and the new wing was being built. The patients, their families and carers were all well-informed of these works and still chose to have their care and treatment there, despite the disruption of noise and in some instances, the availability of rooms.

The interface with HSP is critical to the overall JFPH operations and this is considered accordingly. JFPH engages actively with HSP and is chosen to be the pilot site for new initiatives proposed by HSP. The JFPH staff actively seek these opportunities and are pleased to showcase their achievements with these.

Staff are nurtured and developed as much as they are willing to be. It was pleasing to see staff initially employed on a casual basis, now in senior positions. In the process they have had education and mentoring opportunities offered to them. The skill mix and experience of the staff translate to excellent patient outcomes which JFPH demonstrated throughout the survey process.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

John Fawkner Private Hospital (JFPH) is under the governance of Healthscope Ltd (HSP); policies are promulgated by HSP to JFPH and when appropriate and applicable, JFPH authors Standard Operating Procedures (SOP) to specify their local application of the HSP policy. The SOPs comply with the HSP suite of policies on document control and are well-referenced to legislation, best practice standards and the HSP policy/procedures. There is a document control system in place that is the master index as well as the document that states the due review date. There was an excellent awareness by the staff with respect to both the HSP policies and the JFPH SOPs.

Staff have position descriptions which clearly outline their responsibilities and JFPH's expectations with respect to quality and safety. New staff or staff returning after extended leave have a comprehensive orientation process that has specific requirements around the position for which they have been employed. Agency staff have an orientation package that they are required to complete before commencing duties and they are issued with a credit card sized card, stating that they have successfully completed the orientation.

There is a plethora of training and education opportunities offered and accessed by the staff; these include, and not limited to, in-house education, access to education offered by HSP, external forums and formal tertiary courses.

The quality management system is underpinned by two key HSP policies: the Healthscope Safety and Quality Plan 2017/18 and the local application titled John Fawkner Private Hospital Safety and Quality Plan 2017/18, the latter being the JFPH application of the HSP policy. The Quality Action Plan 2017/18 is the enabling document of the priorities of the organisation for a 12-month period. A further spreadsheet based on a risk assessment framework is the audit schedule and tracking sheet. The JFPH Hospital-Wide Mandatory Training Rolling Database specifies the subject matter titles, the applicable departments and craft groups, and the compliance rate for each of the training modules.

The integrated risk register is enterprise-wide and populated via RiskMan entries, internal and external audits, and compliance reports.

Clinical practice

Risk assessments are commensurate with the patient demographics and are undertaken in accordance with the guiding policy or SOP. Patients identified as 'at risk' progress to having a more detailed risk assessment; eg falls management. An Alert sheet placed at the front of the medical record is a further alert that the patient has been identified as being 'at risk'. The observation charts comply with the human factor principles and there is an escalation of care system in place (refer discussion under Standard 9).

With the exception of the laboratory and medical imaging reports, the medical record is paper-based. The medical record follows best practice filing conventions and audits are completed and reported with respect to KPIs spanning documentation to compliance with using the correct coloured pen for patient care entries. There are three levels of storage for the medical record; these are the primary and secondary storage which are both on site, with the third being off site and a contracted service provided by Recall.

Performance and skills management

The credentialing and granting of clinical privileges to the Visiting Medical Officers (VMO) and employed medical officers is undertaken under the guidance of the HSP policy. There is an initial appointment process with annual ongoing review. The Medical Advisory Committee has governance of the medical credentialing and scope of practice process. Nursing and Allied Health also undergo a credentialing system; nursing staff with advanced scopes have these confirmed by ongoing competencies that are validated at the annual performance review. All staff are subject to annual performance review and a spreadsheet is maintained to ensure that there is full compliance on an ongoing rolling calendar basis. Staff are surveyed via different modalities, spanning a number of satisfaction and needs analysis questions; these are undertaken both internally on specific subject matters and via HSP on broader matters.

There was evidence sighted that this data is analysed, and used for planning and to inform the quality agenda into the future.

Incident and complaints management

The incident and complaints management platform is RiskMan which is a HSP-wide system. There is a high awareness of RiskMan amongst staff, who willingly report incidents. Incidents are followed up and where corrective actions are warranted, these are clearly documented. Complaints form a component of the rights and responsibilities process with patients, their families and carers being made aware of their right to raise concerns regarding any component of the care delivered. Complaints are trended and analysed. JFPH acts upon each and every complaint that is received and uses complaints to make changes as these are identified. There is a healthy incident reporting culture supported by a no blame culture.

Patient rights and engagement

Patients are informed of their rights and responsibilities as a component of their pre-admission package when they are admitted as elective patients, and as a component of information that is given to all patients admitted via the emergency department. The patient satisfaction surveys demonstrate a high awareness of these rights. The Charter of Healthcare Rights is furthermore displayed in public areas throughout the hospital. Patients participate in their care planning to the extent that they wish to be involved. The care boards are an example of a communication tool used so patients are aware at a glance of pending treatments and care.

JFPH takes an active role in educating patients, their family members and carers in Advance Care Planning. Whilst recognising the importance of having this in place, JFPH respects that this is not always culturally or personally acceptable to all patients and these rights are respected.

There are clear privacy policies in place and as a component of the admission process patients are made aware of how their health information is used and to which third party it will be disseminated. There have been no privacy breaches reported.

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

Organisation: John Fawkner Private Hospital
Orgcode: 220189

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Despite the Healthscope (HSP) overlay of partnering with consumers related policies, John Fawkner Private Hospital has embraced this standard and excelled in a number of the actions with Met with Merit ratings.

JFPH has four Consumer Consultants who are very active and proactive in their approach to partnerships and planning. There is a consumer on each and every committee and working party. The consumers have allocated portfolios and are supported and mentored appropriately. They are provided with data in a manner that is non-threatening and able to be easily interpreted. This allows the consumers to provide a contribution to the discussions and therefore the decisions being made by JFPH.

JFPH view the consumers as 'staff' and understands the value adding component that their roles bring and contribute. The consumers run the patient groups where issues that have arisen are socialised with the patients; their feedback is then considered and enacted accordingly. JFPH provided a number of examples of this process.

The Consumer Consultants attend and undertake training. They are supported in a manner commensurate to their individual needs. JFPH invested a great deal of time and resources in applying for The Australian Council on Healthcare Standards (ACHS) Exemplar Award for consumer participation. Components of the Exemplar Award are in excess of the minimum requirements of this standard.

The survey team concurred that actions 2.1.2, 2.2.1, 2.2.2 and 2.3.1 meet the requirements of a Met with Merit rating and these have therefore been awarded.

Consumer partnership in designing care

As discussed throughout this report, patients are core and central to care planning at JFPH. Decision making involves the patient and when applicable, the family and carer. JFPH is undergoing an exciting phase with extensive refurbishment of the current site and the commissioning of a brand-new wing. This has been a protracted process that has involved consumers, engagement with the neighbours and of course, involvement of the local council. In tandem with the physical building requirements has been the models of care that are being proposed. There was discussion on these with patients and the consumer consultants.

Consumer partnership in service measurement and evaluation

The Consumer Consultants and in fact, the patients all contribute to the partnership discussion and the overall evaluation of care and services, be it a formal review of data at a committee level, informal discussions, feedback via complaints or satisfaction experience surveys; each data point is considered, evaluated and used accordingly. The Consumer Consultants could provide numerous examples of improvements and policy changes that occurred as an outcome of their contributions.

The survey team concurred that actions 2.8.1, 2.8.2, 2.9.1 and 2.9.2 meet the requirements of a Met with Merit rating and these have therefore been awarded.

Consumer partnership in service planning

Ratings

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

Action 2.1.2 Developmental

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

Surveyor Comment:

John Fawkner Private Hospital (JFPH) has very active consumers who run focus groups with patients as well as visit patients and their families during their in-patient stay. One of the consumers is from an Italian background and the other three are from an Australian background; despite this, there are no barriers in ensuring that patients from the diverse groups are included in interviews and opinion seeking. Evidence was sighted by the survey team of this in place. Feedback via these forms and interviews are assessed and evaluated and when improvement opportunities are identified, these are put into place. The staff at JFPH are aware of the consumers' roles and engage them as key members of committee proceedings.

Surveyor's Recommendation:

No recommendation

Action 2.2.1 Developmental

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

Surveyor Comment:

The Terms of Reference in place at John Fawkner Private Hospital (JFPH) are clear with the role of the consumers with respect to the committee proceedings. The minutes reflect this practice. JFPH is undergoing significant infrastructure changes with the current building undergoing significant renovations and with a new building in progress. A core component of this was engaging consumers in the commissioning of the works; this engagement continues. There is further engagement with the neighbours who will be impacted by these buildings. Discussions with respect to these works include patient flow and access and ensuring that the models of care being proposed meet the consumers' needs. The building scope has been in place for a number of years and there was substantial evidence sighted that consumer engagement has been long standing. When suggestions to plans were made by the consumers these were considered on their merits and implemented when agreed upon.

Surveyor's Recommendation:

No recommendation

Action 2.2.2 Developmental

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

Surveyor Comment:

Consumers are involved in committees and working parties that address patient safety matters; there are consumers on each of the committees that address the NSQHS Standards and furthermore the quality and safety committee. There is a long-standing involvement of the consumers and each has a portfolio ‘standard’. Data is presented to the consumers in a non-threatening manner that is easily understood and the consumers have been coached to be able to understand and therefore make decisions based on this data.

Surveyor's Recommendation:

No recommendation

Action 2.3.1 Developmental

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

Surveyor Comment:

Three of the consumers at John Fawkner Private Hospital (JFPH) have been in place for a number of years with the newest addition to the team having been recently recruited. The three long standing consumers have evidence of ongoing performance reviews and in fact treated no differently to employed staff. They have been provided with opportunities to attend conferences and workshops commensurate with their learning needs and portfolio areas. The newest consumer member underwent a comprehensive interview, appointment and orientation program in order to ensure that she was equipped and nurtured to tackle the requirements of the role.

Surveyor's Recommendation:

No recommendation

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	MM
2.8.2	SM	MM
2.9.1	SM	MM
2.9.2	SM	MM

Action 2.8.1 Developmental

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

Surveyor Comment:

The consumers are provided with data that is presented in a non-threatening manner that allows them to make decisions. In the lead up to this, the consumers were provided with a laminated sheet with common abbreviations and acronyms to allow them to follow meetings and therefore contribute accordingly. These are long standing initiatives that have been sustained to the present.

Surveyor's Recommendation:

No recommendation

Action 2.8.2 Developmental

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

Surveyor Comment:

Consumers are a component of the committee membership and have held these positions for an extended period. There is no distinction between them and staff members with respect to decision making or having their opinions and viewpoints heard and considered.

Surveyor's Recommendation:

No recommendation

Action 2.9.1 Developmental

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

Surveyor Comment:

John Fawkner Private Hospital (JFPH) place a high and important focus on patient feedback, whether this be via formal letters or anecdotal feedback. The consumers are presented with trended data of the themes and asked to comment accordingly. The consumers run focus groups in addition to visiting patients at the bed side; these meetings

are not only to gauge opinions but to ensure that feedback is provided and furthermore enacted. JFPH has an excellent reactive and proactive feedback system that has been in place for many years and the patient satisfaction and experience surveys confirm this excellent system with the ongoing favourable results.

Surveyor's Recommendation:

No recommendation

Action 2.9.2 Developmental

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

Surveyor Comment:

The consumers as discussed under 2.9.1 play a pivotal role in managing complaints. A core component of this role is to identify systems opportunities and therefore improvements. This is core and central to the consumers being involved and engaged in this process.

Surveyor's Recommendation:

No recommendation

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

John Fawkner Private Hospital (JFPH) Infection Prevention and Control Committee monitors the effectiveness of the infection control system. JFPH Infection Prevention and Control Committee meets bimonthly and reports to the Clinical Governance Committee. JFPH Infection Control Working Party meets four-monthly; the dedicated Infection Control Coordinator and department representatives have terms of reference with clear objectives, revised November 2017.

JFPH has a comprehensive suite of policies and procedures which have a risk management approach. The majority of policies have been revised within a three-year period. Where review of the policy has been delayed, there is evidence of clear communication, the consultation process and the policy review status.

Healthcare Infection Control Management Resources (HICMR) provide support to the organisation across the scope of infection prevention and control, with a robust infection surveillance program inclusive of key performance indicators with benchmarks. It is evident that there is Executive lead for projects within the organisation with clear buy in from staff. Staff stated that they have developed business cases with recommendations to improve infection control systems through improved design, stock management and work flow. The extensive redevelopment project includes the relocation and extension of wards, the operating theatres, and the Central Sterile Services Department (CSSD), which will enhance the infection control environment.

Infection prevention and control strategies

Policies and procedures are in place addressing workplace safety. The Infection Control Coordinator is responsible for the staff immunisation program and maintains the electronic program which captures compliance with screening, and administration of immunisation to enable effective management and monitoring of the immunisation program in compliance with national guidelines. Staff are provided influenza vaccination free annually. Staff compliance in 2017 was 48%.

Staff are made aware of risks associated with influenza with their vulnerable inpatients.

JFPH responded to the east coast outbreaks of gastroenteritis and influenza in the latter half of 2017 which resulted in deaths in Victoria. Staff focus groups were held to provide staff awareness and education for gastroenteritis. It is noted that the catering staff compliance with the education requirements of the food safety program improved from 34% compliance in December 2017 to 96% in March 2018.

Staff compliance with hand hygiene, personal protective equipment and aseptic technique is at a high level. JFPH involves the Medical Officers in the mandatory education and training requirements for infection prevention and control.

JFPH monitors compliance with hand hygiene through the Hand Hygiene Australia project audit program. Gold Standard Hand Hygiene auditors provide confidence in the accuracy of the audit program. Hand Hygiene Australia audit compliance is monitored by each health unit. Hand washing facilities and hand gel/foam are available, with a selection of glove sizes. There is evidence of appropriate signage of the 5 Moments of Hand Hygiene.

JFPH's system for the use and management of invasive devices is based on the current national guidelines for preventing and controlling infections in health care. Compliance with the system is monitored. Staff education in invasive devices is at 100% compliance with the competency-based training. JFPH has access to timely pathology to support the effectiveness of the infection control management system.

Managing patients with infections or colonisations

JFPH standard and transmission-based precautions are consistent with national guidelines. Personal protective equipment is available, with appropriate standardised signage; compliance with standard precautions is monitored. Staff are tested to ensure appropriate fitting of protective masks.

JFPH has an infection control policy relating to the admission, receipt and transfer of patients with an infection or potentially infectious condition. Mechanisms are in place to review the patient for a communicable disease on presentation of care. There is evidence of completion of the documentation for Patient Health History and for the Admission Infection Screening questionnaire. Alerts are reviewed and updated on each admission and documentation is also captured in the electronic system.

JFPH has a policy for when testing of multi-resistant organisms is performed. Management strategies include monitoring of bed allocation and the reduction in bed movement with allocation to a single room as able. JFPH does not have access to negative pressure rooms, and patients will be transferred to another hospital if a negative pressure room is indicated. The requirement for a negative pressure room has been included in the scope of the refurbishment and new wing that is being built. There has been a project undertaken in the emergency department to identify infection/sepsis, with red flags being identified at triage that are leading to timely commencement of empirical antibiotics.

Antimicrobial stewardship

JFPH has an antimicrobial stewardship policy which clearly documents the aim of improving the prescription and management of antimicrobial agents, and minimising selection of resistance through an effective antimicrobial stewardship. JFPH has access to an Infectious Diseases Physician.

JFPH complies with the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory A17/01 version 1 (3 November 2017). JFPH meets the intent of the Advisory through implementing the antimicrobial stewardship program and regularly reviewing and monitoring the program for effectiveness. JFPH can demonstrate it has undergone changes in practice to ensure the patient will receive optimal treatment with antibiotics and good outcomes for timeliness and appropriateness of antibiotic usage.

JFPH conducts clinical reviews and evaluates the diagnosis related groups for compliance with the antimicrobial guidelines. The audit captures the patient, the procedure, the route and antibiotic administered and prescribed. Audits in 2017 identified when antibiotics were being prescribed prophylactically at the time of insertion of the indwelling urinary catheter. Action was taken by JFPH following evaluation of the audit results to change practice. The clinicians have access to the endorsed therapeutic guidelines. Surgical antibiotic prophylaxis booklets were created for each operating theatre in November 2017. Medical Officers have access to the Traffic Light List which identifies restrictions for prescribing antibiotics.

Cleaning, disinfection and sterilisation

JFPH has systems in place to maintain a clean and hygienic environment for patients and caregivers. Considering the extensive building works and the high propensity for dust, the hospital was what could only be described as spotless.

There are clear designated areas for waste management within the external and internal environment. The surveyors noted waste management as being well-organised.

Linen transport is daily; storage, rotation and clean/dirty linen are well-managed. A new schedule for environmental cleaning was implemented in 2018 with 86% compliance.

JFPH complies with the requirements as per the ACSQHC Advisory A16/03 version 3 (28 September 2017). JFPH meets the intent of the Advisory through the documented infection prevention and control gap analysis with risk assessment for compliance with AS4187:2014. The detailed implementation plan has timelines which are currently being actioned. It is noted that while progress has been demonstrated many of the actions/outcomes will be achieved with the new build in October 2019.

The CSSD reprocessing area, although small, is functional for the management of reusable medical equipment, instruments and devices, both JFPH and loan items (ie orthopaedic equipment). There is evidence that there is

compliance with relevant national and manufacturers' instructions. JFPH currently has a manual tracking system. The staff manage well with a large throughput of items through the department each day. The electronic tracking system is scheduled for implementation with the new build.

JFPH ensures the workforce have competency-based training in decontaminating reusable medical devices with staff education at 100% compliance. JFPH has reviewed the storage of clinical stock areas throughout the organisation. The surveyors observed appropriate signage and storage of the stock.

Communicating with patients and carers

JFPH has a consumer on the Infection Control Working Party. JFPH has incorporated best practice clinical resources, using Healthscope, ACSQHC, and Clinical Excellence Commission infection control brochures for access to patient information on the specific infection and the precautions required. Information on the infection is discussed with the patient. Patients are provided with discharge information advising them of their actions if they have signs or symptoms of infection.

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:

JFPH ensures high compliance with mandatory competency training in aseptic technique for clinical staff.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Action 3.14.1 Core

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

Surveyor Comment:

JFPH complies with the requirements of the ACSQHC Advisory A17/01 version 1 (3 November 2017). JFPH meets the intent of the Advisory through implementing the antimicrobial stewardship program and regularly reviewing and monitoring the program for effectiveness. JFPH can demonstrate it has undergone changes in practice to ensure the patient will receive optimal treatment with antibiotics and good outcomes for timeliness and appropriateness of antibiotic usage.

Surveyor's Recommendation:

No recommendation

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:

JFPH complies with the requirements as per the ACSQHC Advisory A16/03 version 3 (28 September 2017). JFPH meets the intent of the Advisory through the documented infection prevention and control gap analysis with risk assessment for compliance with AS4187:2014. The detailed implementation plan has timelines which are currently being actioned. It is noted that while progress has been demonstrated many of the actions/outcomes will be achieved with the new build in October 2019.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

John Fawkner Private Hospital (JFPH) as part of the Healthscope group, has a number of protocols and policies in place to address all aspects of governance for medication safety. There is an active Medication Safety Committee with a designated reporting structure and the use of the cluster groups within Healthscope is also noted. Minutes of their meetings were viewed that support JFPH involvement. Evidence is noted of compliance with full legislative requirements pertaining to storage, labelling and disposal of medications. JFPH was a pilot site for the implementation of the Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC) that has taken the place of the National Inpatient Medication Chart. Audits are produced that show consistently increasing compliance with medication safety.

It is noted that each ward has a medication safety champion to drive all aspects of medication safety. Auditing does reveal a little variability in the mandatory training for medication safety, with areas such as chemotherapy demonstrating approximately 90% compliance and some ward areas being lower, however improvement is noted in these areas. JFPH is encouraged to continue this audit program to achieve higher levels of compliance. The latest overall audit shows levels of 83% in training for medication safety. JFPH subscribes to the Medication Safety Self Assessment (MSSA) program. The latest action plan has been formulated

Documentation of patient information

A Medical Management Plan (MMP) protocol is in place at JFPH. Certain criteria relating to age, co-morbidities, number of medications, etc are used to generate a MMP. Coupled with this is the admission form which has a section for the patients to complete with respect to their current medications. It has been noted that an audit presented in December 2017 demonstrated that only 30% of patient charts had a MMP and of this, only 70% had been correctly completed. This audit was conducted by Hospital Pharmacy Services. After discussion with the appropriate personnel a further audit has revealed significant improvement in this area from the 30% previously stated to 91%. Another area that has been identified at audit is the labelling of intravenous fluids and the signing of medication orders within the 24 hour acceptable time frame. Evidence was sighted that the Medical Advisory Committee (MAC) is aware of these shortcomings and has begun addressing them. Further auditing is required to demonstrate this potential improvement.

Visits to patient areas revealed ready access to medication charts at the point of care, with locked drawers and up-to-date registers of dangerous drugs, including those brought in by the patients themselves. A review of patient charts within the chemotherapy unit showed good notification of patient allergies. Such evidence was also available in the medical ward area, as well as coronary care unit. JFPH's contracted clinical pharmacist is well utilised when an 'at risk' patient has been identified. The clinical pharmacist is involved in medication counselling with this patient cohort. It is JFPH policy that all 'at risk' patients according to criteria laid down regarding age, co-morbidities, polypharmacy etc warrant such a review. At discharge a comprehensive list of medications is provided and copies sent to the referring medical officer. A visit to the pharmacy confirmed such medication lists with plain language instructions to the patient being noted.

Medication management processes

JFPH has an extensive suite of tools available to their staff to enable the efficient management of medications. Hospital Pharmacy Services is the contracted pharmacy provider. There is a pharmacist onsite on week days until 1900 hours and on Saturdays and Sundays for four hours in the morning. There is one full-time and three part-time clinical pharmacists available which allows extensive consultation for 'at risk' patients. The MMP has been instituted to provide these patients with a wide review of their medications and reconciliation at discharge. An extensive list of a patient’s medications is provided on discharge with a copy sent to the referring doctor. Each ward has a dedicated imprest system with pharmacy review for out-of-date medications carried out on a regular basis. It is noted that patient medication is kept in locked drawers within each patient room with access limited to the treating nurse. Each clinical area has a dangerous and restricted drug dedicated locked cupboard. If patients bring restricted drugs with them into hospital these drugs are documented and locked in the ward restricted drugs cupboard and logged in the

register of such drugs. A particular note is made of the initiative to incorporate sliding insulin dosages into the MMP and this is an ongoing process which is monitored regularly. Temperature regulated storage is carried out on a continual monitoring basis. Full legislative requirements are noted for the provision, storage and particularly disposal, of all medications both controlled and non-controlled. Discussion with staff in the operating theatre showed controlled drugs for patient use in this environment followed legal requirements.

Continuity of medication management

JFPH has systems in place that address the medication management of their patients. Inspection of a number of patient charts revealed legible prescribing with evidence of a comprehensive list of medications available at discharge. This list is given to the patient after reconciliation by the pharmacist and is included in the documentation sent to the referring doctor. The generation and distribution of a list of medications, the communication of these at handover, in addition to increasing the proportion of patients and clinicians receiving this list allows Action 4.14.1 to be met (according to Advisory A 16/04). The Day Oncology Unit is particularly rigorous in this regard.

Communicating with patients and carers

In discussion with patients it is clear that there are embedded processes in place to liaise and inform patients of all aspects of their medication. In particular the Oncology Day Unit specifically sets aside up to an hour with each patient before the beginning of a treatment regime to inform and educate. It has been mentioned earlier but it is important to reiterate the use of onsite pharmacy to educate and support the patients in their episode of care. An important factor in discussion with various groups was the ongoing involvement of dedicated consumer volunteers in this process. Their contribution is particularly noted in the various meetings within this standard and the other standards reviewed.

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation: John Fawkner Private Hospital
Orgcode: 220189

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

There is an overarching HSP policy on patient identification and procedure matching with a JFPH SOP. Only two identifier labels are used: that is the white or red patient bands as per national specifications. Patients report via surveys that staff check these before administering medications and/or undertaking procedures. Patients furthermore report an understanding of why this is constantly undertaken and that they are reassured by this system. When there have been patient identification incidents, there was supportive evidence that the incidents were fully investigated and when applicable, mitigation strategies were put in place. Incidents are socialised in order to raise awareness that the incident has occurred, and as a teaching tool.

Processes to transfer care

JFPH transfers care within the facility and external to the facility. Internal transfers are ward to ward, ward to theatre and vice versa; ward to the Intensive Care Unit (ICU) and vice versa, and from the Emergency Department (ED) to the ward. External transfers are to other HSP facilities, either for ongoing management eg rehabilitation services, or for tertiary care or services not provided by JFPH. Transfers to other health care providers, both public and private, also occur when warranted. Transfer of care to community-based providers also occurs. Despite the complexity of the transfer and discharge of care, JFPH has a system in place to ensure that comprehensive discharge summaries are provided. There are headings in the discharge tool to ensure that key care and treatment considerations are fully captured. This tool is underpinned by the ISOBAR system (refer discussion under Standard 6). The Discharge Nurse is involved in all 'high risk' and 'at risk' discharges to the community. This position ensures that support systems are accessed and implemented to support the patient, their family and carer at home.

Processes to match patients and their care

Patients undergo constant checking at each and every level of care and intervention. Patient feedback via consumer forums confirms that patients are in favour of this constant checking as they feel safe that the procedure, intervention and medication administration is what has been prescribed and/or requested for them. Positive patient identification occurs at transfer of care, before a procedure, at handover, and prior to any medication being administered, as a few of the examples.

The Operating Theatres have embedded the World Health Organisation (WHO) Time Out process; this occurs through each level of the theatre journey from admission to the pre-admission holding bay to discharge from the post anaesthetic unit. Co-operation by the surgeons is excellent and furthermore, nursing staff calling a halt to the progress of a theatre procedure is viewed favourably in the setting of all positive identification parameters not being met.

JFPH discussed an incident of a wrong site procedure. This incident led to learnings and opportunities for a review of procedure matching and patient identification.

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation: John Fawkner Private Hospital
Orgcode: 220189

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

John Fawkner Private Hospital (JFPH) has a mature handover system in place that includes positive patient identification. Whilst the two processes are mutually exclusive, they complement each other.

The Healthscope (HSP) policies guide the JFPH application of these policies. JFPH contributes data to the HSP suite of Key Performance Indicators (KPIs) and is benchmarked against HSP hospitals, peers within the HSP group and furthermore, within the cluster. There was evidence sighted that minutes have actions with clear responsibilities in place. As with all JFPH committees and working parties there is consumer involvement (refer discussion under Standard 2). In the event of any handover incidents, these are escalated appropriately and there was evidence sighted of corrective actions being identified and implemented.

A suite of Quality KPIs confirms favourable performance with the exception of discharge summaries being available in the medical record. Action to address this was sighted and is being actively managed.

Clinical handover processes

The JFPH handover process is prescribed by Healthscope and is the Identify, Situation, Observations, Background, Assessment, Recommendation (ISOBAR) process. A handover was witnessed and this confirmed that the ISOBAR process is in place as the staff and patients both participated as equal members of the handover.

Patient and carer involvement in clinical handover

JFPH has communication boards by each bedside; these are intended for the patients. A number of patient discussion groups have occurred and feedback from these meetings has led to improvements in the manner that the boards are managed. The handover witnessed was undertaken in a collaborative, non-threatening manner and with each of the patients they made a contribution and if not the patient, the family member contributed.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation: John Fawkner Private Hospital
Orgcode: 220189

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

The John Fawkner Private Hospital (JFPH) cohort of patients is both medical and surgical and there is a very busy oncology unit, comprising both day only and in-patients. The surgical scope of practice does involve joint replacement and limited cranial surgery with spinal surgery; more recently hepato-biliary surgery has begun to be practised. JFPH therefore has a blood transfusion service overseen by the Blood Transfusion Committee. Inspection of the minutes of their meetings confirmed good governance of all aspects of blood usage. JFPH contributes to the cluster concept with other Healthscope hospitals. Transfusion reactions and incidents are regularly reported via RiskMan and discussed widely with the other hospitals within the cluster. Haemovigilance forms part of this reporting structure. An incident involving an incorrectly labelled blood specimen has led to a major change in the way that blood specimens are labelled. It is now mandatory for all blood specimen labels to be hand written. Inspection of a series of patient files confirmed that the transfusion, including any history of an adverse event, is well noted.

JFPH is registered for BloodStar which is the national data bank for immunoglobulin usage. BloodSafe eLearning rates are noted at 70% and JFPH is encouraged to continue to audit this learning data and to encourage further completion of this learning module.

Documenting patient information

A group of patient files, both active and non-active, was reviewed. Blood information relating to a patient's history included comments from the patients themselves in their admission documentation as well as at the ward level. The JFPH consent process is noted to be different for patients requiring blood, such as in the Oncology Unit, as opposed to transfusion that may be needed during a surgical procedure. Consent for the aforementioned scenario within the medical and oncology wards is a stand-alone form with good documentation of the risks and benefits of the transfusion, and is available in up to 19 different languages. Consent for transfusion during surgery forms part of the overall consent process for the surgical procedure. Transfusion history is noted and forms part of the assessment for pre-transfusion consent. Audits available for inspection confirmed appropriate reasons for transfusion of some 89% of patients. It is noted that auditing revealed consent being obtained in 100% of the notes that were audited. Feedback from questions asked of patients as part of this audit indicated 40% felt their questions had been adequately addressed. JFPH is encouraged to continue with this initiative of patient engagement.

Managing blood and blood product safety

JFPH stores four units of O negative blood in the event of an urgent transfusion and these are kept in a real time monitor refrigerator. Inspection of refrigerator temperatures showed high compliance of 95.3% within acceptable temperature range. A very interesting audit is noted; this involved Policy versus Practice with a large number of questions asked. Such questions as "was blood expiry checked?", "was the transfusion in office hours?", "was the identification checked?" in addition to other questions. The overall audit revealed 96.7% of policy is translated into practice.

Blood wastage is noted with red blood cell wastage 0.13%, platelet wastage 3.6% and cryoprecipitate wastage 0.82%. These figures show a downward trend in wastage in line with current best practice.

A Massive Transfusion Protocol is in place and was recently used with a successful outcome.

Communicating with patients and carers

A full range of literature is available outlining all the risks and benefits of blood and blood products and this is produced in up to 19 languages. The day Oncology Unit undertakes a full hour induction to their patients regarding their treatment which includes the use of blood and blood products.

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Informed consent is an integral part of the hospital processes and the audit results available confirm high compliance. Religious reasons for objecting to transfusions are noted and JFPH is guided by specific protocols if this scenario was to occur.

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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

John Fawkner Private Hospital (JFPH) has a pressure injury prevention, identification and management policy which incorporates screening and assessment forms for managing patients at risk of pressure injuries. The pressure injury and nutrition working party is multidisciplinary providing a review, analysis and shared learning for the management and prevention of pressure injury.

The JFPH Pressure Injury/Nutrition Working Party meets three-monthly and reports to the Clinical Governance Committee. JFPH has a large range of pressure injury prevention and management equipment with regular monitoring of the effectiveness of the equipment by ward. RiskMan is the platform for reporting of all pressure injuries. The pressure injury champion investigates all pressure injuries from the RiskMan reported incidents, and ensures the data is clean for analysis. The coded medical record and the RiskMan data are used to regularly monitor the frequency and severity of pressure injuries.

Preventing pressure injuries

Staff are required to attend pressure injury prevention training annually; in March 2018 there was 95% compliance. The pressure injury risk screening tool is monitored and identifies the patients at risk within eight hours of presentation. JFPH's documentation audit results have good overall compliance.

The pressure injury champion is active in ensuring the follow-up of all pressure injuries and wounds to ensure effective management and strategies are in place. Wound chart audits were conducted in September 2017 with 100% compliance.

JFPH has invested in a wide range of pressure injury prevention and management equipment, which is regularly audited. When the surveyors visited the medical ward a patient stated her satisfaction with the alternating air mattress. Mattresses are audited annually for integrity and replaced as indicated.

Patient-centred care is evident through purposeful patient rounding, application of the turning forms, and the timely access of referrals to Allied Health Professionals and Pharmacy.

The completion of the nutrition and dietetics initial assessment form captures the initial requirements for the patient. The referral to the dietitian ensures a comprehensive assessment utilising the malnutrition screening tool risk assessment form. The dietitian makes recommendations to the care team on the assessment form. Recording of the recommendations from the assessment in the medical record progress notes may improve the timeliness of the implementation and actioning of the recommendations. JFPH has adopted the red tray system for identifying patients requiring help with meals. The 2016 ACHS Hospital Wide Clinical Indicator 3.1 Pressure injury stage 2 and above – hospital acquired is 0.02%.

Managing pressure injuries

Prevention plans are in place and monitored for effectiveness and appropriateness for patients identified as at risk. A spot document review on the day of survey noted that initial prevention plans are in place for at risk patients, but there is a requirement to revisit the prevention plan to ensure all strategies continue and are sustained throughout the admission.

The malnutrition assessments, along with the early involvement from the dietitians, and the red tray system are all strategies to manage patients requiring support with their meals. This is a core component of the pressure injury prevention and management strategy.

The RiskMan system captures reporting of all pressure injury incidents or breaks in skin integrity. There are low numbers of pressure injuries and it is encouraging to see Stage 1 Pressure Injury is reported and managed.

The pressure injury and nutrition working party conducted a case study in October 2016. A patient identified as high risk of pressure injury was hospitalised for an extended period. The patient had a good outcome as the result of effective pressure injury prevention, identification and management.

Communicating with patients and carers

Patient-centred care is evident through purposeful patient rounding, application of the turning forms and the timely access of referrals to the Allied Health Professionals and Pharmacy. The new patient communication boards will assist in the process of ensuring patients are further involved with their care.

The ‘Move Mover Move’ fact sheet is provided to patients with clear information on how to avoid a pressure injury.

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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

Surveyor Summary

Establishing recognition and response systems

John Fawkner Private Hospital (JFPH) has a wide range of policies, both local and Healthscope-wide, to support all aspects of the deteriorating patient. Review of the observation charts in at least three clinical settings revealed good documentation of observations and response to clinical changes. There is a very good system of medical emergency team (MET) calls, with active auditing of the efficacy of these calls. JFPH employs a number of visiting medical officers in the intensive care unit, as well as three full-time medical officers. These three have continuity of service for up to 10 years which gives significant continuity in response. The use of MET calls is monitored. A number of feedback results were available that confirmed good staff appreciation of the benefit of the systems in place for escalation of care. There is a Mortality and Morbidity (M&M) protocol in place with three stages of review of all inpatient deaths. The Medical Advisory Committee (MAC) has instituted craft groups to monitor their own specialities for M&M. As discussed, the feedback in place gives the ability to discuss all aspects of both MET calls and mortality.

Recognising clinical deterioration and escalating care

There is widespread use of the appropriate observation charts with provision for using paediatric and young adult charts where appropriate. These charts follow the so-called “between the flags" system to alert staff to observations outside the so-called norm. The review of these charts revealed clear and legible entries with formal JFPH auditing confirming this observation. Advance Care Directives are noted and it is now policy for each patient to be asked about the provision of such a directive. Literature was noted concerning these directives in the clinical areas.

Responding to clinical deterioration

The escalation for assistance is well-documented and forms an integral component of the orientation of new staff. The percentage of Basic Life Support (BLS) trained staff is over 92%. All the medical staff involved with the ICU who are the first responders on MET calls are trained in Advanced Life Support (ALS) as well as the nursing staff working in this area. This training is carried out at the Royal Melbourne Hospital. There is always a trained ALS person on site. Auditing of the MET calls revealed approximately 12% of patients within the MET call system needed admission to the ICU for further treatment. This figure has been static over the three-yearly audits viewed.

Communicating with patients and carers

Visiting and speaking to both patients and carers within clinical areas showed reasonable understanding of their rights and abilities to initiate a call for help. Over the last 12 month period only two such calls were settled at ward level without the need for escalation. JFPH should continue to stress and include this education for staff and continue to include patients and carers in the ability to initiate help if required. A patient forum in August 2017 revealed that patients needed to be aware of their rights in responding to a change in their condition. The day care Oncology Unit has instigated a face-to-face hour session with their patients and carers at the beginning of their treatment where all aspects, including the ability to escalate their concerns, are discussed and aired.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

The requirements outlined in the advisory regarding ALS and BLS competent staff on site have been fully met.

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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

Organisation: John Fawkner Private Hospital
Orgcode: 220189

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

John Fawkner Private Hospital (JFPH) has a falls prevention and management policy which incorporates screening and assessment forms for managing patients at risk of falls and to reduce harm from falls. The JFPH Falls Prevention Working Party meets three-monthly and reports to the Clinical Governance Committee. JFPH has a large range of falls prevention and management equipment with regular monitoring of the effectiveness of the equipment by ward.

Screening and assessing risks of falls and harm from falling

Staff are required to attend falls prevention training annually; as at January 2018 there was 85% compliance. The requirement is for the falls risk screening tool to be completed within 24 hours of admission of the patients identified as at risk of falls. 96% of these had appropriate falls mitigation strategies put in place.

JFPH has the RiskMan system for reporting of all falls and falls related incidents. The 2016 ACHS Hospital Wide Clinical Indicator 4.1 Patient Falls is 0.14% and Clinical Indicator 4.2 Inpatient Falls resulting in fracture or closed head injury is 0.00%.

Preventing falls and harm from falling

The falls prevention plan captures the comprehensive plan of care. The Quality Manager is active in ensuring the follow-up of all falls. The surveyor reviewed a comprehensive collated report which was inclusive of details of the fall with the patient profile. The falls working party would benefit from receiving this report regularly to facilitate the analysis of the data, and share the lessons learned. The surveyors acknowledge the work within the organisation for delirium management. JFPH provides a safe model of care where personal service assistants are employed to observe patients identified with challenging behaviour and falls risk. There is a procedure for unwitnessed falls where patients will be observed, reviewed by a medical officer, and follow-up treatments implemented as required.

JFPH has invested in a wide range of falls prevention and management equipment, inclusive of the falls mat, mobility and lifting aids, and branded falls prevention grip socks. JFPH has access to Physiotherapist Allied Health Professionals (AHP) and AHP assistants for the management of mobilisation plans. There is also an onsite pharmacist for review of medications that may have a propensity to cause postural hypotension and therefore increase the risk of falls.

Communicating with patients and carers

Consumer engagement is evident with agreement of the falls risk prevention plan. In 2017 JFPH conducted ‘May we assist you?” as a falls awareness campaign for reducing patient falls. The patient discharge is planned and coordinated, and patients identified as falls risk are provided with information, including the Healthscope brochure “keeping a step ahead of falls”.

The recent introduction of the bookmark for patients who have been identified as high falls risk titled ‘simple steps to prevent falls at home’ which includes the seven preventable causes of falls in DOSA and DCU is an example of an initiative to further increase falls awareness with JFPH patients.

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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: John Fawkner Private Hospital
Orgcode: 220189

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: John Fawkner Private Hospital
Orgcode: 220189

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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	MM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	MM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	MM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	MM

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

	• 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	SM	SM

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

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

NSQHSS Survey

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Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

NSQHSS Survey

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Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are 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, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

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

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Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM

9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

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

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

NSQHSS Survey

Organisation: John Fawkner Private Hospital
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Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

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

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Recommendations from Current Survey

Nil

Organisation: John Fawkner Private Hospital
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Recommendations from Previous Survey

Nil

NSQHSS Survey

Organisation: John Fawkner Private Hospital
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Standards Rating Summary

Organisation - NSQHSS V01

Core

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

Developmental

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

NSQHSS Survey

Organisation: John Fawkner Private Hospital
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Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

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

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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: John Fawkner Private Hospital
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Surveyor - NSQHSS V01

Core

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

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

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	3	8	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	**39**	**8**	**47**

NSQHSS Survey

Organisation: John Fawkner Private Hospital
Orgcode: 220189

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	7	8	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	**248**	**8**	**256**	**Met**