Report of the ACHS National Safety & Quality Health Service Standards (NSQHSS) Survey

Knox Private Hospital

Wantirna, Vic

Organisation Code: 22 14 85

Survey Date: 10-13 October 2016

ACHS Accreditation Status: ACCREDITED

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About The Australian Council on Healthcare Standards

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

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

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

1. a customer focus
2. strong leadership
3. a culture of improving
4. evidence of outcomes
5. 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:

1. provide feedback to staff
2. identify where improvements are needed
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. 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 Action Ratings Summary Report
3 Summary of Recommendations from the Current Survey
4 Recommendations from the Previous Survey
5 Standard Ratings 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:

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

2 Actions Ratings Summary Report

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

3 Summary of Recommendations from the 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 Ratings Summary Report

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

Survey Report

Survey Overview

Management and staff of Knox Private Hospital (KPH) presented well for their survey against the ten National Standards. The survey was undertaken over four days, demonstrating evidence of their achievements in improving care and services for patients.

KPH is part of the Healthscope Group of healthcare facilities. It has experienced major redevelopment over recent years taking it from less than 200 beds to a modern 359 bed hospital providing a 24 hour Emergency Department, Intensive Care Unit and Coronary Care Unit and a range of acute care services including surgical, medical, cardiac, obstetric and endoscopy. Patients are admitted on an elective basis under the care of a consultant physician as an inpatient for day surgery or longer admissions.

The hospital's multi-million dollar expansion was completed in 2016 and includes a new 'back of house' area for the kitchen, loading dock, supply and maintenance in addition to a new front entrance to the hospital. The ground floor accommodates additional consulting suites and patient admission and discharge areas, while the first and second floors accommodate two new 30 bed wards. New parking spaces are also available and are now able to accommodate the increasing demand for car spaces on site for patients and staff.

The hospital is well maintained and makes effective use of the site that combines older buildings with newer ones. There are a number of open areas for staff and patients to use with views across to the Dandenongs from upper levels. There are plans to continue to increase the size of the hospital in the future to accommodate 520 beds.

Health services undergoing major redevelopment face challenges at various levels to provide quality and safety and KPH has been no exception to this. While there were some indications of these challenges, the evidence confirmed these issues had been addressed and KPH was continuing to provide quality governance and leadership.

KPH clearly benefits from the Healthscope Corporate Office support through the policy and procedure protocols and there was strong evidence of extensive consultation processes in place for updating policies and procedures to ensure they reflect local requirements.

Significant work has been completed under the leadership of the KPH executive team to ensure the hospital's systems and processes meet the requirements of the ten National Standards. The surveyors were impressed with the high degree of teamwork and the planned integration of services to be provided for patients, carers and clinicians. Management and staff demonstrated commitment to the process and the increasing involvement of consumers through patient surveys and feedback forms, the Consumer Engagement Working Party and Consumer Consultant input.

Information gathered is proactively used to continually drive improvements across all areas of the hospital. Care is of high quality with a strong focus on evidence-based, patient-centred care using numerous tools to screen, assess and monitor care and reduce patient risk. Patients are actively encouraged to participate in their care and a number of improvements have been implemented, such as the introduction of bedside clinical handover and white boards in patients' rooms, and the ability for families and patients to comment on the major development plans.

Of note has been KPH participation in the Victorian Cardiac Outcomes Registry for 'Door to balloon time for primary PCI cases' achieving the best rates in Victoria. This is an excellent result and ensures better outcomes for patients presenting with a heart attack.

An effective Medication Safety Management program is in place across KPH with a suite of evidence-based organisation-wide policies and procedures relating to medication management, with the organisation utilising the National Inpatient Medication Chart. There is a well-structured pharmacy committee and a medication safety sub working group with good reporting lines to Executive level and good support from the HPS Pharmacy team.

Audits are conducted extensively across KPH and individual departments have action plans with quality improvement projects to address their individual issues. Incidents are addressed and reported through RiskMan and staff involved in an incident are required to complete a reflective review of their practice.

Bedside handover is conducted routinely three times a day across Knox, with effective use of the patient boards at

the end of the bed. Also, within the perioperative team, there was good participation by the medical staff in relation to time out protocols.

Blood and blood products are managed well across KPH with an extensive array of evidence-based policies, protocols and procedures in relation to blood management. KPH participates in the HSP Transfusion Cluster which provides guidance and direction in regard to all aspects of blood and blood products, education, policy development, haemovigilance and quality projects. Education is provided to all levels of staff and includes orderlies as they are involved in the transportation of patients to areas within the hospital.

Blood usage is monitored well with audits demonstrating that as usage is decreasing, there has also been a shift towards administering iron infusions rather than using whole blood. As a result of the KPH local committee regarding Blood and Blood Products, informed blood consent has improved with the August/September results reaching 94%.

A system for patient identification and procedure matching is in place that complies with the national standards. The system is overseen by the KPH Patient Identification Working Party, ensuring that regular audits and system reviews are completed. Patient Identification and Procedure Matching is part of the mandatory training program for all staff.

KPH has been innovative and successful in partnering with consumers. As part of the redevelopment of the site, KPH held public meetings to inform the local community of the plans and provision of services that they would be able to access.

Information on KPH is readily available on the website and provides information about the hospital, specialists, events and access to online admission forms. Patients are provided with written information on admission to ensure patients and their families are aware of their rights and the range of services offered by the hospital. Patients are also provided with appropriate information that ensures they are able to provide informed consent; this information is explained to them on arrival and periodically updated to ensure its currency. The organisation is encouraged to continuously monitor the systems and processes that have been implemented to ensure that there is ongoing quality improvement and sustainability.

Core actions in all Standards are satisfactorily met. All developmental actions have been satisfactorily met. Consequently, there are two recommendations provided along with a number of suggestions for improvement contained within the body of the report.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Knox Private Hospital (KPH) is part of the Healthscope group (HSP) that owns and operates hospitals and health services throughout Australia and internationally. Being a private-for-profit organisation there is no local Board with governance provided by the Board of Healthscope. The Corporate Office of HSP holds ACHS EQuIPNational Corporate Health Services accreditation.

The Board of HSP provides leadership and enhances governance by providing a comprehensive policy framework for KPH and monitoring performance in line with the Australian Commission on Safety and Quality in Healthcare and key standards set by various industry peak bodies. These standards are reflected in the HSP Safety and Quality Plan and the Clinical Governance Framework 2016/17 that enables monitoring, reviewing and enhancing safety, clinical risk management and quality initiatives across HSP.

At the local level KPH has its own Quality and Safety Plan linked to the National Plan supported by a monthly reporting system to HSP.

KPH has a Quality and Safety Committee that meets monthly and mechanisms are in place including RiskMan, a Risk Register and consumer feedback systems to seek, monitor and manage quality and risk.

Clinical practice

A range of clinical guidelines is available for all staff on the intranet and at the point of care for all patients admitted to the hospital. Evidence of medical practitioner involvement of new and updated pathways and guidelines such as the new maternity pathway, was noted by the survey team. Regular audits are undertaken to ensure staff are following best practice care options with relatively good compliance rates, and where less than optimal compliance is noted additional staff education and training are provided.

Clinical handover occurs at the bedside three times a day to ensure a focus on patient and family involvement in care.

Staff have ready access to MIMS online and best practice antibiotic guidelines. Patient-centred care is practised and education is provided to staff during orientation and as part of ongoing educational updates.

Comprehensive screening tools are in place to reduce the risk of harm to patients; these are supported by a range of policies and procedures relevant to the setting, and include screening for falls and pressure injuries. Risk management plans are in use and there is very good evidence of steps to reduce harm to patients, such as placing at-risk patients close to the nurses' station, to ensure increased observational checks on patients.

Good systems exist to escalate care; for example, track and trigger observational charts which include escalation processes to guide staff when observations fall outside defined parameters for adults and children.

Patient records are readily available at the point of care; all records are securely stored and maintained as per record management standards. WebPas electronic system is in use to track all medical records and can be used to request patient records. Medical records are culled after 12 months and stored in secure off site storage by Iron Mountain. Clinical coders ensure records are coded within defined coding periods and periodically audited to ensure the appropriateness of coding. Medical record audits ensure compliance and are used to highlight areas for improvement. Outcomes are benchmarked across areas and with other peer hospitals within Healthscope.

There is a system of reporting on safety and quality indicators that are reviewed by the executive level of governance. For example, the quarterly KPI summary compares indicators to HSP targets with KPH required to investigate and report on all adverse trends including comparison to ACHS targets.

RiskMan and the Risk Register are utilised to capture clinical and non-clinical risks, incidents and feedback. Data is regularly reviewed and used to enhance quality and safety systems at KPH.

Actions implemented over the past two years to enhance quality and safety include the introduction of hourly rounding by nursing staff, increased patient involvement in clinical handover, increased clinical audits and more sensor mats for high risk patients.

Performance and skills management

The policy framework for Performance and Skills Management is provided by HSP. HSP also provides a centralised Human Resource Management service.

An organisation chart, position descriptions detailing clinical governance reporting lines and relationships, and a comprehensive Mandatory Training and Orientation Program are in place at KPH.

New procedures, eg robotics, have qualification and training requirements documented to be met prior to granting of clinical privileges.

At the time of survey over 90% of performance reviews were up-to-date. There is an Education Plan in place linked to performance reviews.

A contract is in place with the provider of Nursing Agency staff that specifies the qualifications, experience and training required for employment at KPH. Agency staff represent around three per cent of total nurse staffing.

Incident and complaints management

The policy framework for incident and complaints management is provided by HSP.

Incidents and complaints are well managed. RiskMan and a Risk Register are utilised to monitor and manage incidents and complaints. This is supported by sessions on Risk Management and RiskMan in the Orientation and Mandatory Training Programs. The information from RiskMan and the Risk Register is referred to the National Risk Manager. Interviews with staff confirmed an awareness of their responsibilities in reporting risk and knowledge of how to utilise RiskMan.

Initiatives for improving and strengthening the system include interviews by administration staff at time of discharge, increased rounding by nursing staff, more patient involvement in clinical handover and the installation of patient boards in patients' rooms, are assisting in reducing the number of incidents and complaints.

Patient rights and engagement

Patient rights information, consistent with the National Charter of Patient Rights, is provided to all patients and consumers on admission. This is displayed in the front reception and included in brochures that are provided to patients on admission.

KPH provides documentation to patients and carers regarding patient rights and engagement and supports this with a program on the in-house television system and information on the website.

The Mandatory Training Program includes Open Disclosure, Patients’ Rights and Customer Focus.

There are regular patient satisfaction surveys and initiatives, as detailed in Partnering with Consumers, that have assisted in empowering patients.

Medical records are securely stored and readily available.

Patients are provided with a brochure on Advance Care Planning and Enduring Power of Attorney, where appropriate.

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

Action 1.7.1 Core

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

Surveyor Comment:

Clinical guidelines are available to the clinical workforce, however these have only recently been introduced and do not consistently demonstrate who has authorised them, when they were issued, show version numbers and who has been involved in the process.

Surveyor's Recommendation:

Review the format of clinical guidelines to ensure they indicate those involved in reviews and consultations and are appropriately referenced and authorised.

Risk Level: Low

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The policy framework provided by HSP is supported by the KPH Consumer Engagement Committee and the Community Consultant. Being a member of the HSP Community Cluster and attending both KPH and HSP Strategic Planning days, the Community Consultant presents national and local initiatives for consideration to the local committee.

The Community Consultant is a member of a number of in-house committees, which include the Quality and Safety Committee. The committee is involved in reviewing outcomes of patient satisfaction surveys, patient focus groups and other patient related feedback. Feedback from the committee is used to inform quality improvement across the organisation.

KPH has engaged a Community Consultant to support the process who, as part of the role, is a member of the HSP Community Cluster. The consultant assists in the development of local approaches to partnering with consumers, discusses service planning and meets annually with the General Manager of HSP.

Consumer representatives attend the Strategic Planning Days of both HSP and KPH.

Consumer partnership in designing care

Consumers have contributed to documentation provided to patients, eg brochures for falls, patient controlled analgesia and joint replacements.

Maternity Services hold regular forums/functions with former patients to solicit feedback that was used in the redesign of the Maternity and Neonatal units.

The Community Consultant successfully drives consumer input in designing care, an example being the installation of Patient Care Boards in all patient rooms. The boards provide a more personal approach to patient care by listing requests from the patient, eg questions they want to raise with the doctor and the name of the nurse on duty that will be caring for them.

Consumer partnership in service measurement and evaluation

KPH has been innovative in obtaining constructive feedback from patients and carers. As well as giving patients the opportunity to provide written feedback the Administration Office actively seeks verbal feedback from discharged patients and their carers, and the recently introduced Secret Patient Journey system provides detailed feedback from patients consenting to the process.

The GP and DVA Liaison Officers also contribute to service management and evaluation.

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

There is an effective governance framework for the collection and reporting of infection prevention, control and surveillance data through to the Infection Control, Antimicrobial Pharmacy and Work Health and Safety Committees for their discussion, action and feedback. Information arising from these committees is provided to the Medical Advisory, Clinical Review, Quality, Theatre Advisory and Anaesthetic Advisory Committees and to the Senior Management Review Team. The organisation is supported by Healthcare Infection Control Management Resources (HICMR) which provide best practice and evidence-based policy and practice guidelines along with on-site consultancy. The Infection Control Committee is a multidisciplinary committee and includes an Infectious Diseases Physician, HICMR consultant, clinical and allied health staff. This platform of support and resources provides guidance to the clinical staff in the updating of action plans and the introduction of changes to practice; for example, changes with AS4187 that support the management of preventing and controlling healthcare associated infections.

ACHS and HSP clinical indicator data are collected and benchmarked. The ACHS indicators include VRE infection within non-ICU and ICU areas with infection rates showing 0% for private facilities across Australia.

Infection prevention and control strategies

Infection prevention is a standard agenda item on both ward-based and other relevant committee meetings and staff are regularly updated on outcomes and updated policies. Evidence was provided of staff being informed of changes to policy.

Risk assessments are completed in each department to assess compliance with infection control guidelines. These are further supported through regular auditing and where less than favourable outcomes are noted, action plans are developed and implemented to improve outcomes.

Compliance with Hand Hygiene guidelines is monitored regularly and reported on the hospital website and benchmarked with HSP hospitals. All staff complete hand hygiene eLearning.

The workforce immunisation program complies with National Guidelines, the immunisation status of all staff is known. and flu vaccination rates demonstrated a 50% compliance rate. The organisation is encouraged to continue to improve these rates particularly for staff working with vulnerable patient groups. Work restriction protocols for employees with current infections are in place; for example, staff who have active gastroenteritis symptoms. An appropriate inventory of personal protective equipment is available for staff use and this was evidenced by the surveyors in the clinical setting.

The system for the use and management of invasive devices is monitored for compliance and appropriate education and annual competency is in place. Site specific polices are in place. Aseptic technique education is mandatory for all employed clinical staff and annual aseptic technique competencies are undertaken.

Managing patients with infections or colonisations

The management of patients with infections or colonisations, or patients identified as high risk commences as part of the pre-admission procedure ensuring that appropriate accommodation and management plans are put in place. HICMR assist in ensuring compliance and where required strategies to improve compliance. The organisation has a range of education material for patients and visitors on infection control principles and how they can assist the organisation to maintain these.

Antimicrobial stewardship

The organisation has appropriate systems and processes to comply with the antibiotic stewardship requirement. HICMR policies are in place to support antimicrobial stewardship and HSP policies. Prescribing guidelines, policies and procedures are in place, and records of antibiotic consumption are reviewed by Pharmacy.

An antimicrobial stewardship working party has been established; members include the Director of Nursing, surgeon, six pharmacists, HICMR consultant and pathologist. Auditing of antimicrobial usage is undertaken by Pharmacy staff and results are reviewed by the Antimicrobial Stewardship Committee.

Antibiotics are colour coded (red, amber and green) to indicate if a pharmacist should be involved in the decision to prescribe the antibiotic or to suggest an alternative. A review of antibiotic use for urinary tract infections has been completed and recommendations provided to ensure compliance with Therapeutic Guidelines: Antibiotics.

Antimicrobial stewardship is a standing agenda item on the multidisciplinary Infection Control Committee. Antibiotic stewardship issues are regularly reviewed by Infection Control and HICMR staff.

Educational programs address antimicrobial usage, development of resistance, and judicious prescribing.

Cleaning, disinfection and sterilisation

The organisation presented with a high standard of cleanliness and order across inpatient, procedural, support and communal areas. An established environmental cleaning schedule based on best practice principles and supported by HICMR is in place and regularly monitored. Recent improvements to standardise documentation across the clinical setting were evidenced at survey.

Policies and procedures directing the cleaning, disinfection and sterilisation of reusable devices are referenced to AS 4187.

HICMR risk assessments are undertaken for flexible endoscopes, sterilising services and diagnostic probes.

The theatre suite proactively manages the requirements of storage space for sterile and non-sterile stock that supports the requirements of the standards.

The effectiveness of cleaning, disinfection and sterilisation of reusable instruments and devices is monitored through such means as microbiological testing, heat sensitive strips and periodic validation cycles.

An effective traceability system is in place and the surveyor was able to test the system within the sterilising department. Tracking audits are undertaken every six months to ensure full compliance is achieved and a traceability log is maintained. All staff working within the sterilising department hold appropriate sterilising qualifications and ongoing training is provided.

Waste management complies with policy and has been significantly improved with the introduction of two compactors that has increased storage area as part of the commissioning of the new building.

Food handling practices are audited both internally and by an external auditor.

Room cleaning audits are regularly conducted, and the last one undertaken in August 2016 demonstrated 90-100% compliance. New improvements to cleaning include the use of microfibre mop heads, blue for patient rooms and red for bathrooms; these are used once then removed and laundered.

It was noted on survey that cleaning of BP machines between patients could be improved; recent audits indicated a compliance rate of just 2%. Action plans are in place to improve compliance rates, such as cleaning the machine at the patient bedside rather than outside the room. The organisation is encouraged to continue to address this prior to the next accreditation event.

Communicating with patients and carers

The organisation communicates information on the prevention and control of healthcare associated infections through its website, brochures, pamphlets and clinical handover. ACSQHC patient information brochures on infection control are available on the intranet along with hospital signage.

Patients are provided on admission with written information on infection control and food safety in the KPH Patient Information Directory.

The Consumer Advisory Committee is involved in reviewing the information provided to patients and carers. Hand hygiene products along with education material, are available for use by patients and carers in all areas of the hospital.

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:

A comprehensive organisational risk analysis of aseptic technique competencies has been undertaken and a plan developed. An eLearning training package for the clinical workforce in aseptic technique has been developed and compliance tracked on ELMO. Compliance rates across all areas are consistently high and monitored by nurse unit managers; compliance data is audited and reported as a KPI.

The requirements for 3.10.1 are fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

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

Across KPH there was evidence of governance processes through a well-led multidisciplinary pharmacy committee and a medication safety sub working group. Both groups understand their roles and responsibilities with appropriate reporting lines to the senior meetings including quality and the senior management team. Consideration could be given to including a consumer representative on the pharmacy committee, to provide input into medication safety decision making and quality improvement projects.

The Hospital Pharmacy Service (HPS) is a contracted onsite service that provides a well-monitored service and oversight through the Healthscope cluster meetings.

Education is provided to all levels of staff and includes annual mandatory competency training and in-service by KPH Quality Manager, Educators, HSP staff, and representatives from pharmaceutical companies.

There is a suite of evidence-based policies and procedures in relation to medication management that is consistent with national and jurisdictional legislative requirements. The policies cover medication management and the organisation uses the national inpatient medication chart (NIMC) with medication allergies documented on the NIMC, and on the alert sheet at the front of the record.

At KPH medication incidents are reported appropriately and staff were able to detail the incident notification process and its journey through RiskMan to the senior executive. Nursing staff involved in a medication administration incident are required to complete a reflective review of their practice.

A range of tools is used for assessing the medication management system including audits, RiskMan incident reporting, HSP shared learnings and ACHS Clinical Indicators. The Medication Safety Self-Assessment has also been completed, which has assisted KPH in developing its action plans.

Medication is prescribed and administered within the recognised scope of practice for all levels of staff and includes enrolled nurses.

Extensive work has been conducted across KPH in relation to adherence to policy/procedure regarding telephone orders sign-off within a 24 hour period, with the Senior Executive now involved. Although compliance is improving in pockets across the organisation, audits demonstrate that there are issues with anaesthetist compliance. A recommendation will be made in reference to telephone orders sign-off.

Documentation of patient information

The best possible medication history is obtained pre admission for elective patients and on admission for emergency patients, with medication management plans developed for high risk patients and kept at the patient's bedside and point of care.

Pharmacists from HPS also provide MMP education sessions at KPH.

Adverse drug reactions are reported at the KPH Pharmacy and HSP Cluster Committees with the TGA report available to staff via HINT.

Medication management processes

Decision support tools for medicines are available at the point of care with staff having access to current medicines reference texts: Australian Medicines Handbook, Paediatric Guidelines and Injectable Handbook.

The storage, labelling, rotation of stock, expired stock, recall, and disposal of expired/unwanted medication is coordinated well and managed jointly by KPH and HSP staff. In general the medication refrigerators with temperature gauges were monitored regularly. However, there were occasions where the fridge temperature had not been recorded and in some areas appeared over-stocked. The survey team suggests that further work be conducted in this

area. It was also noted that the medication fridge in theatres is not alarmed and with the theatre unstaffed at night consideration should be given to installing a back to base alarm.

Continuity of medication management

The bedside clinical handover incorporates discussion regarding the patient's medication chart. The Medication Management Plan is also kept at the patient's bedside with the NIMC.

KPH has also developed a patient discharge checklist which lists all of the patient's medications, which has been received well by patients.

Communicating with patients and carers

Communication with patients and carers occurs in a number of settings across KPH. Patients and their carers are engaged regarding medications through the clinical bedside handover process. In addition, high risk patients are counselled by the HSP pharmacists, and nursing staff ensure patients are aware of their drugs at discharge. The organisation also distributes medication information through its TV channel and brochures.

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

Action 4.1.2 Core

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

Surveyor Comment:

Extensive work has been conducted across KPH in relation to adherence to policy/procedure regarding telephone orders sign-off within a 24 hour period. The Senior Executive is now involved and compliance is improving in pockets across the organisation. The audit results demonstrate that there are issues with anaesthetist compliance, which is inconsistent.

Surveyor's Recommendation:

Ensure that the organisation consistently obtains telephone order sign-off within 24 hours to meet legislative requirements and comply with KPH policy and procedure.

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

KPH utilises policies from HSP to comply with National Standards for Patient Identification and Procedure Matching. Two different coloured identification bands are used - white for patients without any known allergies or special needs and red for those with known allergies or special needs. When this is the case an alert system is implemented.

Regardless of the colour, two bands are on each patient - one on the wrist and one on the leg ensuring patient identification should one be removed

Processes to transfer care

There is a robust system for checking patient identification at the various stages in the delivery of care. The surveyors witnessed identification checks and confirmation of care at shift changeover of nursing staff. Interviews with Staff Orderlies confirmed awareness of their role in the patient identification process.

Processes to match patients and their care

Systems are in place to ensure patients are matched to the care and treatment they are to receive.

Operating Theatre staff confirmed time out procedures are in place for every case.

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

A comprehensive policy framework supporting handover practices was evident at KPH. Clinical handover policies include Patient identification, Departmental and Intra Unit, Transfers from the Emergency Department, Correct Patient, Correct Procedure and Correct Site. A range of tools is available to staff on the intranet. KPH has also conducted further work within the Perioperative Department due to identified handover issues resulting in new check lists – Theatre to Recovery and Theatre to ICU handover. These new forms have yet to be formally evaluated.

KPH has a local clinical handover working party whose role is to review policy and compliance, incidents and RiskMan entries, education and quality improvement activities, and monitor poor compliance. Audits are conducted regularly at KPH and cover ten actions including: occurred at bedside, introduction to patient, and addressed clinical diagnosis. As some wards demonstrated audits with 100% compliance in some actions (6/10) and have champions, consideration should be given to introducing clinical handover champions across the whole of KPH.

Clinical handover processes

All handover tools are structured around ISBAR principles and lead consistently from one clinical area to another. Tools and guides are periodically reviewed through a variety of processes. These include the review of Coroner's cases, incident reports, audits and Healthscope Shared Learnings. KPH has developed a video in this area and is awaiting its placement on the local intranet. KPH has also placed clinical handover instructions on the back of the Comprehensive Nursing Management Plan.

Bedside handover is conducted routinely across Knox three times a day. Time out protocols are in place in operating theatres with good participation from medical staff, and the organisation is encouraged to continue to support and foster the leadership of medical staff in this area.

Electronic nurse discharge summaries are provided to patients at discharge and also emailed to the patient's General Practitioner. Incident reports are reviewed and trended by the Quality Unit and presented to the senior committees. Clinical handover is a standing agenda item on the Quality Committee and is registered on the risk register.

Patient and carer involvement in clinical handover

Patients and carers are involved in the handover of their care at several stages of their admission and care. Admission processes are structured and according to survey results patients were satisfied with the level of involvement. The survey team saw at first hand the use of the electronic journey boards and also the patient care boards at the end of the bed where patients are able to see the names of the nurses looking after them.

There was a high degree of satisfaction with bedside handover and its structured consistent approach.

KPH demonstrated positive feedback from the patient impression surveys and although sometimes low in attendance, the patient focus group is an excellent initiative. The mystery patient journey which has occurred also covered aspects of clinical handover.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Evidence-based policies, procedures and protocols were in situ across KPH that related to safe practice and clinical use of blood and blood products. Due to the suite of policies available the survey team suggests that KPH review blood and blood products policies with a view to rationalisation due to the possibility of duplication. There was evidence of compliance monitoring with annual audits conducted in blood transfusion documentation and blood consent.

KPH participates in the National Healthscope Transfusion Cluster Meeting which provides guidance in areas such as policies, education and communication, haemovigilance, projects and transfusion practice review.

Peak committees are provided feedback regarding blood administration and blood related incidents including the KPH Medical Advisory Committee, Clinical Review Committee, KPH Blood and Blood Products Committee and Quality Committee. It is a standing agenda item at the cluster meeting to ensure lessons learnt.

Clinical Indicator data is submitted to the ACHS with clinician information feedback through numerous channels which include, for example, Hospital Safety and Quality Plans and Departmental Meetings.

Documenting patient information

Across KPH there was evidence demonstrating that blood product usage was documented in the patient clinical record with adverse events reported, entered into RiskMan, and minuted at the relevant committees.

Annual mandatory education is provided across KPH with an eLearning blood package available to nursing staff with obstetric staff also completing a Post Partum Haemorrhage management package on line. Night duty staff are provided education after hours and orderlies complete relevant modules as they carry blood within the organisation. All units also have a Blood Resource folder with other resources such as references from Australian Red Cross, National Blood Authority and Blood Safe available on line.

Managing blood and blood product safety

It was evident to the survey team that across KPH there has been extensive work conducted into blood transfusion practices, and audits demonstrated that blood usage had decreased and iron infusion administration had increased.

Regular blood wastage audits demonstrate that there are lower numbers of blood products being ordered and administered.

Blood fridges are managed well across KPH with compliance rates of 100%.

Communicating with patients and carers

Patient and carer resources are readily available and include the Blood Safe Handouts and Fact Sheets with information also available on the TV information channel.

The Blood Safe website has fact sheets available in multiple languages if required.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The governance and systems for the prevention and management of pressure injuries are underpinned by Healthscope policy for 'Pressure Injury, preventing, identification and management of' that is referenced to the Australian Wound Management Association and the 2012 Pan Pacific Clinical Practice Guidelines.

Pressure injury management is regularly reviewed by the Cluster Pressure Injury Prevention Group to ensure a consistent approach to pressure management and to share innovations in pressure management. This group reports quarterly to the National Quality Committee.

HSP National KPIs and ACHS clinical indicators (inpatients who develop more than one pressure injury) are collected and benchmarked, and available to all staff via the HSP intranet.

Preventing pressure injuries

All patients including adults and paediatrics are screened for existing pressure injuries and risk rated for potential pressure injuries at time of admission and daily thereafter. The modified Waterlow pressure risk assessment is used.

Regular auditing of compliance is undertaken and includes the appropriate use of pressure relieving devices and documentation. A recent finding arising from documentation audits demonstrated that staff failed to complete the second side of the screening tool, and as a result the working party is currently redesigning the form.

Following the rebuilding project all pressure relieving equipment is now held and maintained by the Maintenance Department. This has significantly increased access to wards for equipment and ensures that it is fit for purpose prior to patient use.

Managing pressure injuries

A Pressure Injury Working Party is involved in the management of pressure injuries along with the HSP Pressure Injury Prevention and Management Cluster Committee.

High risk patients also have a nutritional risk assessment undertaken which includes malnutrition screening. Also available to staff are patient turn charts, wound charts and negative pressure charts to ensure appropriate recording of information is collected in patient notes.

Trending of pressure injuries is captured through the clinical incident monitoring system, RiskMan, with results provided to all clinical areas.

Communicating with patients and carers

The organisation's website contains information on pressure injury rates for the past three years for Knox Private Hospital. Patients and carers are communicated with daily as part of the clinical handover process. Patients and carers have access to education material including brochures, and the KPH patient TV channel on pressure injury prevention and management.

Consumers have been involved in the development of the information provided to patients and in staff educational programs.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

A Knox Private Hospital (KPH) Quality and Risk Management Framework is in place for clinical deterioration and the rapid response system is aligned with the National Standards emergency plan guidelines.

The Deteriorating Patient Cluster Working Party is responsible for aligning the KPH process with the wider HSP policies and procedures and has a direct reporting line to the HSP National Quality Committee. Terms of reference are in place and are designed to provide a communication network, provide leadership and support, monitor KPIs and develop a central repository of information to support all HSP sites.

A risk analysis of the hospital has been undertaken to identify high risk areas using data from delays in making Medical Emergency Team (MET) calls or failure to call. Data is collected following each MET call on the Emergency Response Data Collection Form. This analysis has been used to strengthen current systems and processes.

KPH treats a wide range of conditions with some in high acuity. This has led to a high standard of recognition and response to clinical deterioration. There has been widespread adoption of the MET call system, for use whenever observations fall outside recognised parameters. Discussion within various wards indicated full knowledge of these systems and appropriate use. Audit results were available which showed appropriate use of the MET call system. There are uniform and standardised charts within the hospital. The 'Between the Flags' charts are in use and have been improved since the last ACHS event to include age specific charts for babies through to adults.

All MET calls are recorded on RiskMan using RiskMan extensions for rapid response/MET calls. Data is reviewed and used to identify areas for improvement in the system. Examples of improvements include the introduction of fluoro vests identifying key MET staff such as the team leader and Doctor, as these roles have not been readily identifiable previously and have led to role confusion on occasions.

Mechanisms are in place for receiving Advance Care Directives (ACD) and Medical Power of Attorney.

Recognising clinical deterioration and escalating care

KPH uses a number of visual observation charts with escalation triggers that are appropriate for the ages of patients. These range from neonatal, four paediatric age adjusted charts, maternity and general. Inspection of a cross-section of both medical and surgical files revealed extensive charting of observations within the various designated clinical parameters. Discussion with staff on the wards indicated their knowledge of when and how escalation was needed.

Regular audits are undertaken on the general observation chart and maternity and paediatric visual observation charts. Data is used to inform a quality dashboard which is in turn used as a trended data report. This contains information such as the number of code blue calls (inpatient), number of deaths (inpatient), number of ISR 1 & 2 events and number of mortalities. Data is reviewed at a number of committees, including the Mortality and Morbidity Committee, KPH Clinical Deterioration Working Party and HSP Clinical Deterioration Cluster where areas for improvement are identified and actioned.

Responding to clinical deterioration

All staff are trained in basic or advanced life support during orientation and annually for both adults, neonates and children. eLearning - an education package - is a mandatory training requirement which is combined with competency assessments.

There is always a medical practitioner attached to ICU or the Emergency Department with Advanced Life Support (ALS) on site. In addition, staff are available 24 hours a day from ICU, Emergency and Coronary Care that are competent in ALS. The majority of medical staff are Visiting Medical Officers (VMOs) and as such KPH has no competency rates for VMOs. However these staff are rarely first responders to a clinical deterioration.

Communicating with patients and carers

Observation within the wards and in discussion with patients and relatives confirmed their awareness of the ability to escalate concerns to KPH staff. The use of hour rounding charts reminds staff to involve families and carers in the use of the emergency buttons located in all patient rooms and bathrooms.

It is noted there are yellow emergency assist signs in each patient room, outlining the process if either patient or visitor is concerned. Families also have access to the KPH patient TV channel that provides information on how to escalate any concerns that they may have.

Patient care boards and bedside clinical handover are also used to communicate any concerns.

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:

A comprehensive organisational risk analysis of basic life support training needs has been undertaken and a plan developed to ensure that the clinical workforce can initiate appropriate early intervention and respond to life-sustaining measures in the event of clinical deterioration. Training in basic life support has been completed by 100% of clinical staff and advanced life support training provided to staff in emergency, ICU, recovery and theatres. The full requirements of 9.6.1 have been met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

A Healthscope policy, along with site specific policies and procedures, provides effective governance and systems in the prevention of falls. ACHS and HSP clinical indicators are collected, trended, severity rated and benchmarked. The ACHS indicators include 'Inpatient falls' and 'Inpatient falls resulting in fracture or closed head injury' and 'Inpatient falls in patients 65 or over'. Data indicates that a number of falls are occurring in these areas but a proactive approach is being taken to reduce them. Falls have significantly dropped over time and the HSP Cluster Falls Prevention Working Party continues to identify areas for improvement, such as targeting falls in bathrooms.

National safety and quality data is reported quarterly to the Healthscope Board. Updates arising from the working party are reported through to the Quality Committee and KPI data is benchmarked across HSP. Falls prevention audits are regularly conducted and data used to identify areas for improvement. Audits include documentation and environmental reviews.

Screening and assessing risks of falls and harm from falling

All patients are screened for falls as part of the pre-admission process which includes a patient health questionnaire related to recent falls, pre-admission clinic and emergency department. A Falls Risk Assessment Tool is in use across the hospital and includes the day procedure centre and wards, theatres and catheter labs.

Screening also occurs post-surgery, after changes in physical or psychological conditions, or post a fall or transfer.

Audit results on the use of the screening and risk assessment tool have demonstrated incremental improvement and the organisation is encouraged to continue its sound work in improving compliance.

Preventing falls and harm from falling

There is a multidisciplinary team approach to the prevention of falls. This is complemented with a broad inventory of equipment including walking aids, non-slip socks and sensor mats. All falls incidents are captured on the incident reporting database and reviewed by the Nurse Unit Managers with feedback to the clinical staff.

Staff are able to refer some privately insured patients to the BUPA home support program when a falls risk is identified. Other high risk patients are referred to alternative providers as required and provided with an information package by a physiotherapist on falls prevention as part of the discharge planning process.

Numerous improvements have been implemented since the last ACHS event; these include the introduction of a falls newsletter for staff, a product review that led to an increase in the number of sensor mats, the introduction of a traffic light warning system on patient boards indicating high falls risk patients, and the introduction of a selection and mobility aid guide for staff.

The HSP shared learning report is used to identify areas for improvement across all sites, including falls prevention strategies.

Communicating with patients and carers

The organisation's internet site contains information on fall rates since 2011 along with suggestions for falls prevention while in hospital. Bedside clinical handover allows the patient and carer to be involved in the management of falls prevention and the rationale behind the management plan. A range of brochures and educational information is available for patients and carers.

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM

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

Performance and skills management

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

Incident and complaints management

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

1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures	SM	SM
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM

3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

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

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM
3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM

3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM

4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

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

Continuity of medication management

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

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM

4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

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

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

Recommendations from Current Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.7
Action: 1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce

Surveyor's Recommendation:

Review the format of clinical guidelines to ensure they indicate those involved in reviews and consultations and are appropriately referenced and authorised.

Standard: Medication Safety
Item: 4.1
Action: 4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines

Surveyor's Recommendation:

Ensure that the organisation consistently obtains telephone order sign-off within 24 hours to meet legislative requirements and comply with KPH policy and procedure.

Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.6.2 Actions are taken to maximise patient quality of care

Recommendation: PR+ NS 0811.1.1.1

Recommendation:

The review of patient care assessment documentation reduces duplication of assessment questions to patients.

Action:

2012:
Healthscope implemented a review of high cost high use medical record forms including patient assessment forms. Patient health, falls risk assessment tool, observation charts and fluid balance charts were included in the review.
2013:
Patient Health Questionnaire:
Implemented August 2013 and includes falls risk screen, skin integrity screen, CJD and acute respiratory illness screen questions.
The new form has eliminated the need for the previous CJD and acute respiratory illness screening form.
Adult Observation Chart:
This form has replaced a previous combined observation form / progress note and concurrent observation form used for documentation of bowels and intravenous sites. The introduction of integrated progress notes and firstly more appropriate use of care tracks and secondly new patient management care plans has made a form redundant.

A major project of the Health Information Service has been a review of the HMR and MR numbering of the medical record forms and during this process identification of duplicate forms are identified for review.
As medical records are reviewed for coding and forms are identified that are not on the HMR and MR list, the form is noted and listed for review by the Health Information Manager.
There has been significant work in archiving redundant forms and revising forms to ensure the forms meet the needs of the user group.

2014:
There have been no newly identified duplication of forms in 2014.
Knox forms have been updated for best practice and compliance with AS2828 (Information Management memo 2 June 2014).
Knox new forms available for use following review notified to staff (Information Management memo 2 June 2014).
HMR forms for review continue with the Healthscope Clinical Cluster and includes:

- Maternity 'track & trigger' form - Obstetric Cluster
- Wound Chart - General Quality Cluster

As medical records are reviewed for coding and forms are identified that are not on the HMR and MR list or appear to be duplicated, the form is noted and listed for review by the Health Information Manager.

2016:
KPH Documentation Working Party commenced with key objectives to include identification of duplicate medical record forms, photocopied forms and the removal of redundant KPH medical record forms that have been replaced with Healthscope forms.
Photocopied forms identified include:

- ACAS referral form - to be reviewed and sent to HSP National Forms Committee for formatting to a KPH MR form

- KPH Consent for Photography form - reviewed against HSP Policy 8.05. Verbal Consent is required and to be documented in the medical record and therefore no form is required. The form is to be archived.
- KPH Additional Patient Observation and Pain Management Chart - reviewed and replaced with KPH MR6.1F
- HICMR Admission Screening Questionnaire - to be replaced with HSP form and currently with National Forms Committee. HICMR questions are currently being updated for September 2016.

Completion Due By: 30 November 2014

Responsibility: Quality Manager

Organisation Completed: Yes

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

KPH forms have been updated for best practice compliance with AS2828.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Clinical practice
Action: 1.8.2 Early action is taken to reduce the risks for at-risk patients

Recommendation: NSQHSS Survey 0913.1.8.2

Recommendation:

KPH develop and implement clinical improvement projects on clinical areas showing adverse trends to ensure that the cause is identified and actions are implemented to make improvements to outcomes and ultimately patient care.

Action:

The Knox Quality KPI report includes clinical and non clinical criterion. The quarterly report is reviewed with the General Manager and submitted to the Healthscope (HSP) National Quality Manager for review and tabling at the HSP Quality Committee and summary at the HSP Board of Directors Meeting. At Knox the information is reviewed at the Quality Committee meeting and the different criteria at Committees / working parties.

Outliers are escalated to the Clinical Review Committee and Specialty craft committees.
For each Quality KPI Report, a Quality plan is completed for any outlier and submitted as part of the same report.

2012 - 2013 Quality KPI report:
Unplanned readmissions for Hip Replacement:
Oct - Dec 2012 = 2.74% (HSP target = <0.5%). Action Plan submitted in same report and available for review by surveyors: All readmissions involved different VMO's. Would require no readmissions each quarter or greater than 200 separations per quarter to reach target. Reviewed at KPH Clinical Review Committee.
Jan - March 2013 = 5.13% (HSP target = <0.5%). Action Plan submitted in same report and available for review by surveyors: Unplanned readmission x 4 (2 x surgeons - different months for each surgeon); 3 were infection related,1 x mechanical prosthetic joint related. Would require no readmissions each quarter or greater than 200 separations per quarter to reach target. Reviewed at KPH Clinical Review Committee.
April - June 2013 = 5.63% (HSP target = <0.5%) Un planned readmission x 4. (3 x different surgeons).
If there was a particular trend identified, the Clinical Review Committee would recommend the review of clinical data with the admitting VMO or the establishment of a speciality medical group for peer group review of practices and performance.

2013/2014 onwards: This indicator is no longer collected as a separate indicator for the Quality KPI Report.

Patient Falls:
HSP Target = <0.3%
July - Sept 2012 = 0.35%.

- The Quality action plan with the KPI report documents that 71% of falls were unwitnessed. All patients had a falls risk assessment completed. Risk prevention strategies and interventions to be discussed at staff meetings for implementation and review.

Oct - Dec 2012 = 0.32%.

- The Quality action plan with the KPI report documents a decrease in actual fall numbers. Nurse Unit Managers to complete falls audit in own departments.

Jan - March 2013 = 0.31%.

The Quality action plan with the KPI report documents an increase in falls per patient bed day. Falls audit by Quality Manager - gaps in Falls risk assessment. Discussed at Nursing Leadership meeting. Nurse Unit Managers to complete department falls audit.

April - June 2013 = 0.40%.

- The Quality action plan with the KPI report documents an increase in the number of falls per patient bed day. An increase in referrals to allied health Jan - March (16%) to April - June (23%). In-service education planned for August 2013 and SDLP reviewed for KPH and available on eLearning. Falls audit completed by Nurse Unit Managers on wards and increased reporting of slips from chairs. Queensland patient falls audit near completion and identified beds have 2 locking positions and staff education to reinforce to use highest lock position.
  The Action plan was attached the Quality KPI report for review.
  The information was reviewed at the above listed committees.

2014/2015:
Quality KPI results: falls rate = 0.30 - 0.40%
2015/2016:
Quality KPI results: falls rate = 0.27 - 0.37%
Action taken:

- Review of individual incidents by Nurse Unit Managers
- Department In-service education including audit results
- Introduction of hourly rounding
- Purchase of sensor mats.
- Daily email stream of patient falls in hospital
- Further purchase of sensor mats; reconciliation of sensor mats / parts and new process for storage and availability to ensure improved access for all departments.
- Review of monthly Riskman incident reports at KPF Falls working party and trend reports over 3 month and 6 month periods.

2013 - 2014 Quality KPI Report:
Unplanned readmission to Hospital within 28 days: ACHS HW CI 1.1
HSP Target = <0.4%:
July - Sept = 0.65%
Oct - Dec = 0.38% (met target)
Jan - March = 0.66%
Apr = June = 0.84%
Action Plans for each quarter discuss the concern regarding accuracy of data collection. A WebPas enhancement program for coders to allocate a patient file for 28 day readmission at time of coding has been implemented around

march 2013 with the first report run for the April - June 2013 quarterly report. This has reduced the WebPas report review for exclusions for 28day readmission data. Medical physician review of patient medical records to confirm planned or unplanned readmission criteria met has commenced from the April - June 2-13 period. The results indicate further education of coders and VMO is necessary.

2014/2015:
Quality KPI results: rate = 0.77 - 0.56%. Lowest rate = 0.48%
2015/2016:
Quality KPI results: rate = 0.50 - 0.67%. HSP target = 0.39%
Action taken:

- Case review by Senior Health Information staff.
- Overall review by Health Information Manager

2016:

- Identified cases where there is any clinical reason for further review are allocated for review by Nurse Unit Manager, Intensive Care Unit
- Monthly review of database by Quality Manager and identification of cases for further analysis
- Review of results with General Manager and Executive. No trends identified with clinical issues. Infections identified on a monthly basis by Quality Manager and reviewed by HICMR Consultant for any trends and nosocomial infections.

Unplanned return to the Operating Room During the Same Admission: ACHS HW CI 2.1
HSP Target = <0.23%:
July - Sept = 0.28%
Oct - Dec = 0.22% (met target)
Jan - March = 0.38%
Apr = June = 0.47%
Action Plan for each quarter with outlier discussed with Nurse Unit Manager Perioperative Services. Data collection reviewed with Clinical Nurse custodian for clinical indicator - no identifiable trend in clinical issue or medical practitioner. One case sent for clinical review by VMO to ascertain if surgery was planned or unplanned. Spread sheet developed to allow for more detailed analysis of data from July 2013.

2014/2015:
Quality KPI results: rate = 0.43 - 0.44%. Lowest rate = 0.34%
2015/2016:
Quality KPI results: rate = 0.33 - 0.25%. HSP target = 0.19%
Action taken:

- Case review by Associate Nurse Unit Manager and Nurse Unit Manager Perioperative Services
- Case review with Quality Manager
- Results and case presentation discussed at Theatre Advisory Committee.
- Trend reports discussed at Theatre Advisory Committee.
- Return to Theatre cases are primarily elective surgery cases.

Unplanned Admission to ICU or HDU within 24hrs of a procedure: ACHS Anaesthetic CI 4.1
HSP Target = <0.13%:
July - Sept = 0.07% (met target)
Oct - Dec = 0.18%
Jan - March = 0.15%
Apr - June = 0.33%
Action Plan:
October - December 2013: the ICU Manager to identify any trends in clinical cases for unplanned admission to ICU. January - March 2014: a review of the clinical indiactor with the PARU Manager and ICU Manager identified the most appropriate department to collect the data was ICU. The data would be more accurate as previous data collected only included transfer from PARU and data would now include all admissions such as patient transfer following metcalls

that meet the criteria. The second half yearly reports note to have an percentage increase in results as KPH has an onsite ICU.

2014/2015:
Quality KPI results: rate = 0.46 - 0.06%.
2015/2016:
Quality KPI results: rate = 0.02 - 0.05%. HSP target = 0.11%
Action taken:

- Review of Clinical Indicator definition and ensuring HDU patients are excluded from the data collection.
- Intensive Care Unit staff became the custodian data collectors for the indicator rather than perioperative anaesthetic staff.
- Case review for data collection by Nurse Unit Manager Intensive Care Unit and Quality Manager.
- Clinical indicator data collection guide subsequently changed in HSP guide following KPH review of processes.

Unplanned Return to the Operating Room for a Day Patient: ACHS Day Patient CI 5.1
HSP Target = <0.03%:
July - Sept = 0.04%. 1 x patient return to Operating room following identification of lesion on tongue not removed at time of surgery.
Oct - Dec = 0.00% (met target)
Jan - March = 0.04% 1 x patient return for reinsertion of stent.
Apr - June = 0.11% 3 x patients return for ongoing bleeding. All different VMO's.
A comprehensive spread sheet is kept for each Day Procedure Clinical Indicator to enable data analysis and review.

2014/2015:
Quality KPI results: rate = 0.08 - 0.04%.
2015/2016:
Quality KPI results: rate = 0.03 -0.00%. HSP target = 0.11%
Action taken:

- Individual case review to ensure the return to theatre is related to the original procedure.
- Return to theatre is related to most commonly uncontrolled bleeding requiring further intervention

Unplanned Transfer or Overnight Admission by a Day Patient: ACHS Day Patient 6.1
HSP Target = <0.03%:
July - Sept = 0.04%.
Action plan:
Review of data to ensure operations past 12MN are no longer included as overnight admissions but remain as day patients - technical issue with WebPas. Ongoing pain management identified as main clinical reason for overnight admission.
Oct - Dec = 0.00% (met target)
Jan - March = 0.04%
Apr - June = 0.11%
Action Plan:
reasons for readmission identified and main clinical reasons were pain management, further surgery, unstable observations and ongoing treatment.
Clinical indicator results and outliers are reviewed at the Quality Committee and Clinical Review Committee (CRC). The CRC and Theatre Advisory Committee requested further information on the Day Procedure Clinical Indicator outliers.

2014/2015:
Quality KPI results: rate = 2.73 - 1.95%. HSP target = 0.83%
2015/2016:
Quality KPI results: rate = 2.4 - 2.56%. HSP target = 0.77%
Action taken:

- Review of Clinical Indicator definition for data clearance accuracy.
- Review of data collection by Quality Manager and Deputy General Manager.

- Identification of Day Case lists with a trend for overnight admissions and additional cases that transfer to overnight admissions. For discussion with Visiting Medical Practitioners on planning of day cases and overnight case admissions.

Hospital Acquired Bacteraemia:
HSP Target = <0.04%:
July - Sept = 0.38%. (met target)
Oct - Dec = 0.41%. Action plan stated: 1 x blood stream infection in a patient with multiple co-morbidities & multiple intravenous cannula; treated with appropriate antibiotics and antivirals
Jan - March = 0.44%. Action plan stated: 1 x VATS and complicates surgical emphysema. Antibiotics administered at inductions, treatment according to pathology results.
Apr - June = 0.00% (met target)
All nosocomial reports reviewed and compiled by HICMR Consultant and tabled at Infection Control Committee for review. Any issues of concern are referred to the Clinical Review Committee for consultation.

2014/2015:
Quality KPI results: rate = 0.00%. HSP target = 0.4%
2015/2016:
Quality KPI results: rate = 0.00%. HSP target = 0.4%
Action taken:
Nosocomial monthly reports submitted by HICMR Consultant at Infection Control Committee following review of Pathology reports.

Clostridium Difficile Identified in Hospital:
HSP Target = <2.0%:
July - Sept = 1.89%. (met target)
Oct - Dec = 4.08%.
Jan - March = 2.20%.
Apr - June = 2.97%
Action plan for each quarter with an outlier stated ' continued monitoring by hospital staff'.
HICMR Clostridium Difficile management tool kit available on website and each clinical department. Clinical staff are vigilant in reporting undiagnosed reasons for testing for clostridium difficile or related pathology and reporting same to Infection Control Co-ordinator and VMO. Infection Control Co-ordinator completes a daily round of patient in transmission based precautions and following discussion with staff more readily identifies patients who may have clostridium difficile and are subsequently tested for same.
The analysis of data reflects patients admitted with clostridium difficile (community acquired) compared with patients who have hospital acquired clostridium difficile.

2014/2015:
Quality KPI results: rate = 3.14 - 2.80%. Lowest rate = 1.18%. HSP target = <2.0%
2015/2016:
Quality KPI results: rate = 2.29 - 2.10%. Lowest rate = 1.57% HSP target = <2.0%
Action taken:

- HICMR Clostridium Difficile management tool kit available on website and each clinical department.
- Clinical staff are vigilant in reporting undiagnosed reasons for testing for clostridium difficile or related pathology and reporting same to Infection Control Co-ordinator and VMO.
- Infection Control Co-ordinator completes a daily round of patient in transmission based precautions and following discussion with staff more readily identifies patients who may have clostridium difficile and are subsequently tested for same.
- The analysis of the data reflects patients admitted with clostridium difficile (community acquired) compared with patients who have hospital acquired clostridium difficile
- The HSP target rate is to be reviewed for 2016 / 17 (HSP Managers conference)

Clostridium Difficile - Healthcare Associated:
HSP Target = <0.5%:
July - Sept = 0.00%. (met target)
Oct - Dec = 0.82%.
Jan - March = 0.00%. (met target)
Apr - June = 0.85%

Action Plan: October - Dec 2013 - to review with symptom onset to ensure criteria met. April - June 2014: To have data reviewed at Quality Committee and Antimicrobial Stewardship meetings for comment.
2014: HICMR has developed a comprehensive clostridium difficile reporting form to ensure hospital acquired clostridium difficile data is captured clearly from community preadmission clostridium difficile infection.

2014/2015:
Quality KPI results: rate = 0.39 - 0.00%. HSP target = 0.05%
2015/2016:
Quality KPI results: rate = 0.38 - 0.35%. HSP target = 0.05%
Action taken:

- HICMR has developed a comprehensive clostridium difficile reporting form to ensure hospital acquired clostridium difficile data is captured clearly from community preadmission clostridium difficile infection.
- HICMR Clostridium Difficile management tool kit available on website and each clinical department.
- Clinical staff are vigilant in reporting undiagnosed reasons for testing for clostridium difficile or related pathology and reporting same to Infection Control Co-ordinator and VMO.
- Infection Control Co-ordinator completes a daily round of patient in transmission based precautions and following discussion with staff more readily identifies patients who may have clostridium difficile and are subsequently tested for same.
- The analysis of the data reflects patients admitted with clostridium difficile (community acquired) compared with patients who have hospital acquired clostridium difficile

Pressure Injury - Hospital Acquired: ACHS HW CI 3.1:
HSP Target = <0.04%:
July - Sept = 0.08%.
Oct - Dec = 0.06%.
Jan - March = 0.12%
Apr - June = 0.13%
Action Plan:
Education sessions for pressure injury prevention and management held in August and November 2013. Wound champions in key clinical departments as resources for staff and support for wound consultants. Mattress audit completed for hospital and roll out of replacement mattress commenced. January - June 2014: Stage 2+ pressure injuries reviewed by wound consultants and no increased status of wounds noticed - only improvement. Staff education continues.

2014/2015:
Quality KPI results: rate = 0.09 - 0.07%. Lowest rate = 0.06%. HSP target = 0.04%
2015/2016:
Quality KPI results: rate = 0.05%. HSP target = 0.02%
Action taken:
2015 / 2016: Department education sessions for staff by Wound Care Consultant.
2015 / 2016: eLearning package reviewed and allocated to staff for completion
2016: Purchase of 10 replacement additional air mattresses.
2016: Wound consultant reviews riskman reports and patients identified with Stage 2 pressure injuries
2016: Trial of preventative pressure relieving product for heels and sacrum.
2016: Education of staff on correct classification of wounds for dermatitis, continence related excoriation and pressure injuries
2016: Education for clinical coders on correct coding of pressure injuries by Wound Consultant
Results are reviewed at KPH Pressure Injury Working Party and Quality Committee.
Quality KPI report is reviewed by Quality Manager and General Manager and KPI review and sign off prior to submission to HSP Quality Committee.

Severe Pressure Injury - Hospital Acquired:
HSP Target = <0.01%:
July - Sept = 0.05%.
Oct - Dec = 0.03%.
Jan - March = 0.05%
Apr - June = 0.07%
Action Plan: As noted in Quality KPI report - Education sessions for pressure injury prevention and management held in August and November 2013. Wound champions in key clinical departments as resources for staff and support for

wound consultants. Mattress audit completed for hospital and roll out of replacement mattress commenced. January - June 2014: Stage 2+ pressure injuries reviewed by wound consultants and no increased status of wounds noticed - only improvement. Staff education continues

2014/2015:
Quality KPI results: rate = 0.02 - 0.01%. HSP target = 0.01%
2015/2016:
Indicator no longer collected for Quality KPI report.
Action taken
Action taken for improvement as per above strategies.

Completion Due By: June 2016

Responsibility: Quality Manager

Organisation Completed: Yes

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

Adverse trends are identified in quarterly KPI reports comparing results to HSP targets. Management investigates negative variations from these targets, eg comparison to ACHS targets, whether the trend is doctor or procedure driven, etc and provides the information to HSP as part of the regular monthly reporting system.

HSP then advises if a clinical improvement project is warranted and if so this is implemented by KPH.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Clinical practice
Action: 1.8.3 Systems exist to escalate the level of care when there is an unexpected deterioration in health status

Recommendation: NSQHSS Survey 0913.1.8.3

Recommendation:

1. Implement the set of 'Track and Trigger' Paediatric Forms.
2. Review the system for maternity patients to ensure further improvement can be made to the current procedure and system for responding to acute clinical deterioration in neonatal, paediatric and maternity patients

Action:

Paediatric 'Track and Trigger' Forms
2013:
The Healthscope Standard Paediatric Observation Chart (SPOC) Under 3 months, 3 - 12mths, 1 - 4years, 5 - 11years, 12 years and over were reviewed by the Healthscope Obstetric Cluster and paediatric nurses at relevant hospitals, including KPH.
The form was trialed at KPH from September 2013 - April 2014.
The KPH Paediatric Metcall criteria was amended to reflect the five SPOC chart calling criteria for clinical deterioration in September 2013.

2014:
June 2014: The five HSP SPOC forms were accepted following the trial and have been implemented at KPH.

December 2014:
Audit completed of Paediatric visual observation chart. Actions identified include completion of full set of observations and graphing of observations.
December 2015:
Audit completed of Paediatric visual observation chart. Actions identified include completion of full set of observations and graphing of observations.

Maternity Patient - Clinical Deterioration Management:

2013:
Adult Observation 'Track and Trigger' Chart implemented for maternity patients - antenatal and post natal.
KPH clinical review and metcall criteria apply for maternity patients using the Adult Observation Chart.
HSP Obstetric Cluster continue to develop maternity 'Track and Trigger' Observation Chart.
PIPER (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary

2014:
Increased compliance with Metcall and Clinical Review as evidenced by Riskman entries for Clinical Deterioration - Maternity Unit.
HSP Working Party for Maternity 'Track & Trigger' form includes KPH Maternity Unit Nurse Unit Manager and Quality Manager.
2014 June - August: Four forms reviewed included modified Eastern Health network form (modified) and ACHA form (modified) as submitted by KPH.
2014 September: KPH form resubmitted for review
2014 September: HSP draft form circulated for comment.
2014 October: KPH feedback provided to incorporate additional best practice and clinical guideline updates, and format review.
2014 November: HSP draft form circulated for feedback.

2015:
Implementation of Maternity visual observation chart following further trials at Knox Private Hospital and selected sites.
December 2015:
Audit completed of Maternity visual observation chart. Actions identified include completion of full set of observations and graphing of observations.

Paediatric Patient - Clinical Deterioration Management:

2013 September: The KPH Paediatric Metcall criteria was amended to reflect the five SPOC chart calling criteria for clinical deterioration.
2014 June: HSP Paediatric 'Track and Trigger' charts age specific implemented at Knox.
Clinical review is managed via contact with the Treating Medical Practitioner. Review by ED Physician available as necessary.
Metcall is attended by the Met team including attendance by the ED medical practitioner.
PIPER (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary.

Neonatal Patient - Clinical Deterioration Management:

KPH Maternity staff complete the ENAMS Newborn Care (including neonatal resuscitation) mandatory education module via Intellilearn annually.
2013 KPH = 98%
2013 & 2014: PIPER (formerly NETS & PETS) education sessions on neonatal and paediatric resuscitation attended by KPH maternity staff.
Neonatal clinical deterioration:

- Treating Paediatrician called for advice or attendance
- Onsite Paediatrician, if consulting, called for assistance
- Emergency Department Physician called for assistance
- Paediatric Anaesthetist called for assistance if necessary
- **PIPER** (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary

2015:
PIPER (NETS) education on site for maternity staff and offered to Visiting Medical Staff who are rostered for the Met and Code Blue teams

2016:
PIPER (NETS) education on site for maternity staff and offered to Visiting Medical Staff who are rostered for the Met and Code Blue teams.
2016 September 14: 26 Maternity staff, 3 Emergency Medical Staff, 2 Intensive Care Fellows and 1 Paediatrician are enrolled to attend the course.

Completion Due By: 31 December 2014

Responsibility: Director of Nursing

Organisation Completed: Yes

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

1. The Track and Trigger Paediatric Forms have been implemented in 2013 in age categories and reviewed by the HSP cluster and the paediatric nurses at KPH.

2. The Track and Trigger Chart for Maternity patients was implemented in 2013 and has been regularly reviewed.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Performance and skills management
Action: 1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement

Recommendation: NSQHSS Survey 0913.1.11.2

Recommendation:

Review current Performance Review process, including a system for monitoring Manager and Executive's own performance in achieving targeted percentage on staff performance review - three-monthly after initial appointment, then annually.

Action:

Performance Appraisal Management:
2014:
Performance Appraisal monthly report is tabled at the Senior Management Team meeting for review and discussion by Managers.
Department lists are available for review from KPH Administration HR / Payroll ro review for accuracy and updates as necessary.
Managers are responsible for ensuring 3 monthly appraisals are completed in a timely manner.
Performance appraisal completion is KPI one of the KPI's on the Manager's Business meeting agenda with their Executive Team Leader.
2014: New KPH Administration HR / Payroll employee appointed and personnel files / performance appraisal database updated.
June = 74% compliance with performance appraisal completion

2016:
For review at survey and discussion with Hospital Executive.

Completion Due By: September 2016

Responsibility: Director of Nursing

Organisation Completed: Yes

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

The performance review process has been reviewed and includes monitoring the Manager and Executive's own performance in achieving targeted percentage on staff performance review - three-monthly after initial appointment, then annually.

The overall completion of performance reviews is over 80%

Standard: Medication Safety
Criterion: Governance and systems for medication safety
Action: 4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines

Recommendation: NSQHSS Survey 0913.4.1.2

Recommendation:

1. Undertake a quality improvement project to review the current policy on medical staff sign-off on telephone orders and attaining compliance.
2. A review of the Pharmacy Committee be conducted at the conclusion of the first 12 months of the committee being operational, and then annually to assess the committee's own performance and effectiveness.

Action:

NIMC - Telephone Orders Signed by Medical Practitioners:
HSP Policy 8.50: Ordering Medication - verbal reviewed and updated May 2014
Documentation Audit 2013:
Surgical = 32% (HSP average 45.73%)
Medical = 21%(HSP average 49.63%)
ICU = 50% (includes general ward data) (HSP average = 48.89%)
Neonatal and Obstetric Units not completed for this year.
Outcome:
Overall improvement however remains below target for signing of telephone orders by VMO within 24hrs.

2014 Quality Improvement Project:
Telephone order sign off project to determine factors as to why Medical Practitioners are not signing the medication orders within 24hrs and the number of days the patients are in hospital from the time of the medication order to the time of the audit.
Medical and Surgical wards were included in the audit.
Outcome:
Audit identified the following issues:

- majority of charts audited noted that Medical Practitioners had visited their patients post telephone order of medications
- medication order related to admission medications - can be signed at first visit by medical practitioner
- medications order for additional analgesia and nausea options can be reduced by selective prn medication prescribing options

- identification of medical practitioners to discuss practice improvement opportunities.
- Chesterfield Ward had best compliance with telephone orders being signed by VMO's. A green sheet filed with the NIMC chart with reminders for the relevant Medical Practitioner to sign telephone orders and complete other medication related issues has improved compliance with this issue. The KPH Medication Safety has recommended this initiative be trialed in all clinical departments and regular audits be completed for evaluation of the trial.

2014 NIMC Audit:
% of drug order type signed by prescriber:
Stat only orders (includes phone orders / nurse initiated orders and therefore nursing staff / medical practitioner orders) = 75.67%

2014 Documentation Audit:
KPH documentation audit completed in October and results are pending.

Pharmacy Committee:
2014 November:
Evaluation form distributed to the Pharmacy Committee members for completion.

2015: NIMC Audit:
% of drug order type signed by prescriber:
Stat only orders (includes phone orders / nurse initiated orders and therefore nursing staff / medical practitioner orders) = 68.75%

2016:
Clinical departments have developed different strategies to engage the Visiting Medical Officers (VMO) to improve compliance with signing of telephone orders in 24hrs as per policy and this includes:

- Green laminated sign filed with NIMC form as a reminder to the VMO
- Telephone order reminder page in the Nursing Management folder to reminder the Nurse In Charge and VMO of telephone orders that require signing
- Laminated sign that protrudes from the patient's red bedside folder and is placed next to the NIMC form. The sign states 'telephone order to sign'.
- Documentation daily audits has included telephone orders to sign.
- Telephone order audit.

Results of August / September 2016 Telephone Audit includes:

- Improved compliance for signing of telephone orders - variations does occur by departments and on days of the week
- VMO's are asking for telephones orders to sign
- Anaesthetists are highlighted as not signing telephone ordered pre medication orders at Perioperative visit. This is to be discussed at the Anaesthetic Advisory Committee.
- The individual VMO's named in the August / September audit are to be advised of the result by the General Manager.

Completion Due By: December 2014

Responsibility: Director of Nursing

Organisation Completed: Yes

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

1. A quality improvement project was undertaken which included the introduction of a laminated sheet into the red point of care folder, with the laminated sheet sitting above the notes so that it is easily detected. The A/NUMs also have a folder that indicates if there are any orders outstanding. There have been some improvements noted. A report is now submitted to the General Manager for follow-up with the Medical Officer.

2. A review of the Pharmacy Committee has been undertaken with minor revisions made to the Terms of Reference.

Recommendation: PR+ NS 0811.1.5.1#2

Recommendation:

Ensure the sign off of telephone orders meet jurisdictional requirements.

Action:

2012:
National Inpatient Medication Chart (NIMC) currently does not have a designated section for VMO sign off for telephone orders within 24hrs. The NIMC is currently being revised and the new format will have a section for VMO sign off of telephone orders to encourage compliance with HSP policy regarding authorisation of medication telephone orders.
2012 February:
Medical Units: VMO compliance with signing of telephone orders = 29% (HSP average = 46%)
Obstetric Units: VMO compliance with signing of telephone orders = 36% (HSP average = 46%)
2012 November:
The NIMC form is waiting approval from Medicare for release early 2013.
2013:
The Healthscope group of NIMC forms is waiting approval from Medicare for release in September 2013. The scriptless Knox Private Hospital NIMC form has been approved for use in the hospital.
Visiting Medical Officer information evening presentation on Quality and National Standards by Healthscope National Quality Manager included Medication Safety and the requirement to sign telephone order within 24hrs.
The current NIMC does not have a time space for VMO's to document the time of authorising the telephone order, this has been rectified in the updated version of the NIMC form.
A fluorescent green page 'Dr's Orders' has been commenced as a quality initiative in wards as a reminder 'to do' list for Doctors on their next visit to their patient. The page is next to the NIMC and primarily has reminders about signing phone orders and other medication related requests for the medical practitioner. This has stopped the practice of 'post it notes' being lost and being in multiple areas with a greater capture rate of orders being signed by medical practitioner.
Next documentation audit due September / October 2013.

NIMC - Telephone Orders Signed by Medical Practitioners:
HSP Policy 8.50: Ordering Medication - verbal reviewed and updated May 2014
Documentation Audit 2013:
Surgical = 32% (HSP average 45.73%)
Medical = 21%(HSP average 49.63%)
ICU = 50% (includes general ward data) (HSP average = 48.89%)
Neonatal and Obstetric Units not completed for this year.
Outcome:
Overall improvement however remains below target for signing of telephone orders by VMO within 24hrs.

2014:
Quality Improvement Project:
Telephone order sign off project to determine factors as to why Medical Practitioners are not signing the medication orders within 24hrs and the number of days the patients are in hospital from the time of the medication order to the

time of the audit.
Medical and Surgical wards were included in the audit.
Outcome:
Audit identified the following issues:
- majority of charts audited noted that Medical Practitioners had visited their patients post telephone order of medications
- medication order related to admission medications - can be signed at first visit by medical practitioner
- medications order for additional analgesia and nausea options can be reduced by selective prn medication prescribing options
- identification of medical practitioners to discuss practice improvement opportunities.
- Chesterfield Ward had best compliance with telephone orders being signed by VMO's. A green sheet filed with the NIMC chart with reminders for the relevant Medical Practitioner to sign telephone orders and complete other medication related issues has improved compliance with this issue. The KPH Medication Safety has recommended this initiative be trialed in all clinical departments and regular audits be completed for evaluation of the trial.

2014 NIMC Audit:
% of drug order type signed by prescriber:
- stat only orders (includes phone orders / nurse initiated orders and therefore nursing staff / medical practitioner orders) = 75.67%

2014 Documentation Audit:
KPH documentation audit completed in October.
Medical / Surgical results: 24.62% telephone orders signed by VMO in 24hrs (HSP average = 58.50%)

2015: NIMC Audit:
% of drug order type signed by prescriber:
Stat only orders (includes phone orders / nurse initiated orders and therefore nursing staff / medical practitioner orders) = 68.75%

2015 Documentation Audit:
KPH documentation audit completed in October.
Medical / Surgical results: 20.00% telephone orders signed by VMO in 24hrs (HSP average = 43.31%)

2016:
Clinical departments have developed different strategies to engage the Visiting Medical Officers (VMO) to improve compliance with signing of telephone orders in 24hrs as per policy and this includes:

- Green laminated sign filed with NIMC form as a reminder to the VMO
- Telephone order reminder page in the Nursing Management folder to reminder the Nurse In Charge and VMO of telephone orders that require signing
- Laminated sign that protrudes from the patient's red bedside folder and is placed next to the NIMC form. The sign states 'telephone order to sign'.
- Documentation daily audits has included telephone orders to sign.
- Telephone order audit.

Results of August / September 2016 Telephone Audit includes:

- Improved compliance for signing of telephone orders - variations does occur by departments and on days of the week
- VMO's are asking for telephones orders to sign
- Anaesthetists are highlighted as not signing telephone ordered pre medication orders at Perioperative visit. This is to be discussed at the Anaesthetic Advisory Committee.
- The individual VMO's named in the August / September audit are to be advised of the result by the General Manager.

Completion Due By: December 2014

Responsibility: Director of Nursing

Organisation Completed: Yes

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

KPH has conducted extensive work in this area by regular audits that have identified areas and followed this up by raising with particular medical groups. It has been addressed and whilst results fluctuate it is clear that staff are aware of the issue and taking reasonable actions to attempt to gain total compliance.

Standard: Medication Safety
Criterion: Medication management processes
Action: 4.10.6 Action is taken to increase compliance with the system for storage, distribution and disposal of medications

Recommendation: PR+ NS 0811.1.5.1#5

Recommendation:

Medication storage imprest systems in clinical units be overseen by a pharmacist and underpinned by best practice storage solutions for LASA and high risk / high alert medications.

Action:

2011:
The National Tallman lettering list published by ASQHC was discussed at the Healthscope Medication Safety Cluster 2011. The information was distributed to the Knox Private Hospital Pharmacy Committee members and tabled at the following meeting for review and comment. The Tallman lettering system was considered and following comments received from HSP Corporate Office and general comment is was agreed not to implement the system at the time. High risk medications such as chemotherapy where the system is considered beneficial are not dispensed and administered at Knox Private Hospital.
LASA medications are currently being managed as per medication safety strategies by:

- manufacturing companies changing product labelling to differentiate LASA medications
- high risk medications identified by staff being notified to companies, HSP National Pharmacy Manager or HSP Procurement, or TGA for notification of potential risks
- purchasing strategies being reviewed to avoid the purchase of LASA medications

2012:
Deputy General Manager, Pharmacy Committee Chair, is currently consulting with Third Party Provider of clinical pharmacy services on the medication safety management of imprest systems within the hospital. The review will be completed in consultation with the KPH Executive, HSP National Pharmacy Manager and with regard to the ASQHC guidelines for best practice.

2013:
August:
Review of Third Party Provider contract: inclusive of implementation of tallman lettering to differentiate LASA medications.

2014:
March:
HPS Pharmacies' innovation in developing our dedicated clinical management system, Hospharm®, has provided the flexibility to once again lead the industry in the implementation of quality improvements, such as the introduction of Tall Man Lettering.

In accordance with the guidelines, the changes will appear on the selection screen of our computers, client invoices and statements, drug lists, reports, and imprest shelf labels. The changes will not appear on patient dispensing labels or medication profiles. Some manufacturer have introduced Tall Man Lettering on the package labels, to facilitate accurate recall and selection. (HPS Pharmacy Knowledge Centre - March 2014)
May:
HSP Shared Learning Report - Medication Safety 2.1 TallMan Lettering. Advice provided that Healthscope Tech 1 system able to provide labels required for Tallman lettering as applicable.
Imprest labels for medications requiring Tallman lettering in progress.
November:
Tallman labels when printed are not 'fit for purpose' when supplied by company. Healthscope recommendation via National Quality Cluster (November 2014) to place action 'on hold' until further resolution of print issue.

2016:
The TallMan lettering system has been implemented for all imprest labels in medication store rooms, imprest stock labels and pharmacy labels.
This applies to hospital imprest supplied and HPS Pharmacy supplied medications.
Tallman lettering information provided in each department medication room for staff reference.

Completion Due By: March 2014

Responsibility: Director of Nursing

Organisation Completed: Yes

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

Medication storage is now supervised by a Pharmacist and complies with best practice storage solutions.

Standard: Blood and Blood Products
Criterion: Communicating with patients and carers
Action: 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

Recommendation: NSQHSS Survey 0913.7.11.1

Recommendation:

Ensure that informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the relevant health service policy.

Action:

Blood Consent for Transfusion of Blood and Blood Products

2013:
May:
KPH Inservice Presentation on Consent for Blood Transfusion and Blood Products developed for KPH and Bellbird Private Hospitals. Presentation was also shared with all Healthscope Hospitals.
Inservice sessions conducted for clinical staff. Attendance records kept on file.
Education evening for Medical Practitioners included a session on National Standards presented by the HSP National Quality Manager and incorporated blood consent.

Blood Consent Audit:
KPH = 13% compliance with completion of consent form (surgical consent)

Blood resource folders update for each clinical department inclusive of patient information brochures and sample consent forms
Quality Information flyers circulated to All Knox email users regarding policy on blood consent.
Blood consent forms available in clinical departments

Department of Health Audit - Consent for Blood Transfusion:
August: KPH = 4% (Victorian Hospitals (public & private) = 32%. Sample number = 27.

2014:
Blood Consent Audit:
July = 44% compliance with completion of consent form (surgical consent and HMR4.7B)
Patient information flyers available at Blood Fridge for ease of access for nursing staff when collecting blood.

HSP Policy 8.64 Blood Transfusion: Management of Patient, Blood and Blood Products updated August 2014 to change the guidelines for obtaining patient consent in private hospitals when the Medical Practitioner is not onsite.

2014 November:
KPH eLearning and Inservice presentation updated to include most recent information on how to obtain consent for blood transfusion.

2015:
2015 December consent audit = 70% completion
Knox has an Emergency Department, Intensive care Unit and undertakes emergency surgery. In accordance with Healthscope Policy emergency transfusions do not require a consent form to be completed at the time of a blood transfusion.

2016:
2016 January: Blood consent = 83%
2016 May - June: Blood consent = 61%
2016 July: Blood consent = 64% to be reconciled with emergency transfusions
2016 August: Blood consent = 73% to be reconciled with emergency transfusions

Action Plan:

- Blood consent audit is included as ACHS Clinical Indicator: HWCI 6.2
- Data collection process was reviewed with Health Information Manager and Quality Manager and data is now collected at time of coding.
- Reconciliation of medical records to be completed by the Quality Manager to exclude emergency blood transfusions from the data collected.
- Process review by the KPH Blood and Blood Product Working Party to develop new initiatives for obtaining blood consent from patients.
- Patient information brochures on blood transfusions: increased accessibility in the Emergency Department, Pre Admission Clinic and new laminated sheets for all patient red bedside folders.
- A list of all VMO's not completing the Blood transfusion consent on the Consent for Surgical Procedures or HMR Blood Transfusion Consent form has been provided to the General Manager for discussion with the relevant VMO's.

Completion Due By: July 2015

Responsibility: Quality Manager

Organisation Completed: Yes

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

There are regular audits to measure informed consent in accordance with the health service policy.

Recommendation: PR+ NS 0811.1.1.3

Recommendation:

Ensure documentation of informed consent for transfusions blood or blood products is completed by medical officers in accordance with the HSP policy requirements.

Action:

2012 March:
Blood Consent audit results: 100 patient records audited; 11 consent for blood transfusion obtained = 11% compliance for consent for blood transfusion.
Results presented at Quality Committee meeting and Medical Advisory Committee.
Results are part of the suite of Healthscope Quality audits for completion for the year 2011 / 2012 for submission to Healthscope National Quality Committee.
2012:
HSP Hospital Transfusion Working Party has completed throughout the year the final version of the HSP Blood Consent form as approved by the Healthscope Chief Medical Officer. Draft versions have been tabled at the Knox Medical Advisory Committee for review and comment.
2012 November:
Department Of Health Victoria Blood Consent audit currently being completed, including patient questionnaire on blood consent. Results are unavailable at the time of report.

2011 / 2012:
Healthscope Quality KPI's submitted to HSP National Quality Committee quarterly have for the first time included a suite of audits that have reflected the National Standards and this has included a blood consent audit.

2012 / 2013:
Healthscope Quality KPI's submitted to HSP National Quality Committee quarterly includes a suite of audits that reflects the National Standards and this has includes a Transfusion Consent audit to be completed annually.
Knox Private Hospital is currently participating in the Department of Health, Victoria Transfusion Consent audit.
Complete

2013:

Blood Consent Audit:
KPH = 13% compliance with completion of consent form (surgical consent)
Blood resource folders update for each clinical department inclusive of patient information brochures and sample consent forms
Quality Information flyers circulated to All Knox email users regarding policy on blood consent.
Blood consent forms available in clinical departments

Victorian Department of Health Audit results (received August 8 2013):
N= 27
consent document = 4%; comparison hospitals = 75%
did the patient recall receiving information in the consent process = 4%; comparison hospitals = 32%
Action:
Visiting Medical Officer information evening included a session presented by HSP National Quality Manager on Quality and National Standards. The presentation included the issue of informed consent for blood transfusions.
Patient information flyers available in Blood resource folder in each clinical department and in several languages.
Patient information flyers laminated and placed in patient bedside chart folders.
Patient information flyers located alongside the blood fridge and available for staff to take when collecting blood.
Communication notices distributed to remind staff to provide information sheet about blood transfusions prior to

receiving a transfusion.

2014:
Blood Consent Audit:
July = 44% compliance with completion of consent form (surgical consent and HMR4.7B)
Patient information flyers available at Blood Fridge for ease of access for nursing staff when collecting blood.
August:
HSP Policy 8.64 Blood Transfusion: Management of Patient, Blood and Blood Products updated August 2014 to change the guidelines for obtaining patient consent in private hospitals when the Medical Practitioner is not onsite.
November:
KPH elearning and inservice package updated to include most recent information on blood consent.

2015:
2015 December consent audit = 70% completion
Knox has an Emergency Department, Intensive care Unit and undertakes emergency surgery. In accordance with Healthscope Policy emergency transfusions do not require a consent form to be completed at the time of a blood transfusion.

2016:
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2016 July: Blood consent = 64% to be reconciled with emergency transfusions
2016 August: Blood consent = 73% to be reconciled with emergency transfusions

Action Plan:

- Blood consent audit is included as ACHS Clinical Indicator: HWCI 6.2
- Data collection process was reviewed with Health Information Manager and Quality Manager and data is now collected at time of coding.
- Reconciliation of medical records to be completed by the Quality Manager to exclude emergency blood transfusions from the data collected.
- Process review by the KPH Blood and Blood Product Working Party to develop new initiatives for obtaining blood consent from patients.
- Patient information brochures on blood transfusions: increased accessibility in the Emergency Department, Pre Admission Clinic and new laminated sheets for all patient red bedside folders.
- A list of all VMO's not completing the Blood transfusion consent on the Consent for Surgical Procedures or HMR Blood Transfusion Consent form has been provided to the General Manager for discussion with the relevant VMO's

Completion Due By: June2013

Responsibility: General Manager/Quality Manager

Organisation Completed: Yes

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

There are regular audits regarding medical officer completion of informed consent which reveal compliance of 13% in 2013 to compliance of 94% in September 2016.

It remains work in progress, however the improvement is excellent.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Establishing recognition and response systems
Action: 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

Recommendation: NSQHSS Survey 0913.9.1.2

Recommendation:

Complete the implementation of the initiative in improving the system for the recognition and response to clinically deteriorating children and obstetric patients by implementing the 'Track and Trigger' Paediatric and Obstetric observation forms.

Action:

Paediatric 'Track and Trigger' Forms
2013:
The Healthscope Standard Paediatric Observation Chart (SPOC) Under 3 months, 3 - 12mths, 1 - 4years, 5 - 11years, 12 years and over were reviewed by the Healthscope Obstetric Cluster and paediatric nurses at relevant hospitals, including KPH.
The form was trialed at KPH from September 2013 - April 2014.
The KPH Paediatric Metcall criteria was amended to reflect the five SPOC chart calling criteria for clinical deterioration in September 2013.

2014:
The five HSP SPOC forms were accepted following the trial and have been implemented at KPH since June 2014.
An audit will be completed of the forms in November 2014.

Maternity Patient - Clinical Deterioration Management:
2013:
Adult Observation 'Track and Trigger' Chart implemented for maternity patients - antenatal and post natal.
KPH clinical review and metcall criteria apply for maternity patients using the Adult Observation Chart.
HSP Obstetric Cluster continue to develop maternity 'Track and Trigger' Observation Chart.
PIPER (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary

2014:
Increased compliance with Metcall and Clinical Review as evidenced by Riskman entries for Clinical Deterioration - Maternity Unit.
HSP Working Party for Maternity 'Track & Trigger' form includes KPH Maternity Unit Nurse Unit Manager and Quality Manager.
2014 June - August: Four forms reviewed included modified Eastern Health network form (modified) and ACHA form (modified) as submitted by KPH.
2014 September: KPH form resubmitted for review
2014 September: HSP draft form circulated for comment.
2014 October: KPH feedback provided to incorporate additional best practice and clinical guideline updates, and format review.
2014 November: HSP draft form circulated for feedback.

2015:
HSP Obstetric Cluster reviewed and submitted for trial 3 versions of visual observation chart.
Knox trialed maternity visual observation chart.
HSP Obstetric Cluster approved final version of maternity visual observation chart.

Maternity Visual Observation chart implemented at Knox Private Hospital.
Paediatric Age adjusted visual observation charts x 4 reviewed and implemented at Knox Private Hospital.

2016:
Maternity visual observation chart: revised due to error in observation of temperature scale
Documentation audit of chart completed for compliance with last set of observations.
Audits results: Full set of observations not completed, some written observations documented and not all graphed observations. The charts were recently implemented and there was a transition period to the new charts for staff. Re-audit September 2016.

Completion Due By: June 2015

Responsibility: Quality Manager

Organisation Completed: Yes

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

The Track and Trigger Paediatric and Observation Forms were implemented in 2013. There is an HSP working party that monitors this matter, including regular audits.

Recommendation: PR+ NS 0811.1.1.2

Recommendation:

Observation charts be redesigned to include human factor principles by the graphical representation of physiological observations and include paediatrics and obstetrics.

Action:

2012 February:
HSP Clinical Deterioration Working Party established with representatives from nursing (ICU and general), education and quality. Knox Private Hospital Intensive Care Unit Manager has represented this hospital on the working party.

2012 March – August:
HSP Policy 8.45 Clinical Deterioration, Recognising and Responding to; developed and authorised.
Development of the Adult General Observation chart reflecting the rapid response criteria – national standards.
Trial of the Rapid Response Chart on 3 wards, audit of results and presentation of audit results to staff at KPH by ICU Manager. Results submitted to HSP Clinical Deterioration Working Party for review. The results and comments supported further modifications to the trial chart.

2012 November:
HSP Adult General Observation Chart (graphical) form available for use by each hospital. This form is graphical form of observation and a visual representation of the colour coded rapid response criteria.
HSP Working Party currently developing a draft Obstetric graphical observation chart for clinical deterioration. A paediatric chart for clinical deterioration is being sourced for consideration by the this working party.

2013:
Healthscope Clinical Deterioration Working Party finalised the design of the Adult General Observation chart incorporating the human factor principle elements by the graphical representation of physiological observations.
Knox Private Hospital established a Clinical Deterioration Working party.
Education on the Adult General Observation chart and Rapid Response Systems.
Implementation of the Adult General Observation chart.
Inservice to individual clinical departments on the new chart.
Audit of the application of the chart against set criteria. Results discussed with clinical departments.

HSP Obstetric Clustetric with the Healthscope Clinical Deterioration Working Party developing the Obstetric 'track and trigger' observation chart. Currently two versions are being reviewed with input from maternity clinicians, educators and rapid response teams.

HSP Clinical Deterioration Working Party reviewed the best practice age group related Paediatric 'track and trigger' charts.
2013 July: Paediatric charts - following review were accepted and approved for print.
2013 August: Currently waiting notification of the Paediatric 'track and trigger' form being available from the printers.

Paediatric 'Track and Trigger' Forms
2013:
The Healthscope Standard Paediatric Observation Chart (SPOC) Under 3 months, 3 - 12mths, 1 - 4years, 5 - 11years, 12 years and over were reviewed by the Healthscope Obstetric Cluster and paediatric nurses at relevant hospitals, including KPH.
The trail form was used at KPH from September 2013 - April 2014.
The KPH Paediatric Metcall criteria was amended to reflect the five SPOC chart calling criteria for clinical deterioration in September 2013.

2014:
The five HSP SPOC forms were accepted following the trial and have been implemented at KPH since June 2014.
An audit will be completed of the forms in November 2014.

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2013:
Adult Observation 'Track and Trigger' Chart implemented for maternity patients - antenatal and post natal.
KPH clinical review and metcall criteria apply for maternity patients using the Adult Observation Chart.
HSP Obstetric Cluster continue to develop maternity 'Track and Trigger' Observation Chart.
PIPER (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary

2014:
Increased compliance with Metcall and Clinical Review as evidenced by Riskman entries for Clinical Deterioration - Maternity Unit.
HSP Working Party for Maternity 'Track & Trigger' form includes KPH Maternity Unit Nurse Unit Manager and Quality Manager.
2014 June - August: Four forms reviewed included modified Eastern Health network form (modified) and ACHA form (modified) as submitted by KPH.
2014 September: KPH form resubmitted for review
2014 September: HSP draft form circulated for comment.
2014 October: KPH feedback provided to incorporate additional best practice and clinical guideline updates, and format review.
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2015:
HSP Obstetric Cluster reviewed and submitted for trial 3 versions of visual observation chart.
Knox trialed maternity visual observation chart.
HSP Obstetric Cluster approved final version of maternity visual observation chart.
Maternity Visual Observation chart implemented at Knox Private Hospital.
Paediatric Age adjusted visual observation charts x 4 reviewed and implemented at Knox Private Hospital.

2016:
Maternity visual observation chart: revised due to error in observation of temperature scale
Documentation audit of chart completed for compliance with last set of observations.
Audits results: Full set of observations not completed, some written observations documented and not all graphed observations. The charts were recently implemented and there was a transition period to the new charts for staff. Re-audit September 2016.

Completion Due By: March 2013

Responsibility: Director of Nursing

Organisation Completed: Yes

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

Observation charts, including paediatrics and obstetrics, have been redesigned to include human factor principles and have been implemented; the most recent review being in 2016.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Responding to clinical deterioration
Action: 9.6.1 The clinical workforce is trained and proficient in basic life support

Recommendation: NSQHSS Survey 0913.9.6.1

Recommendation:

Provide ongoing review and regular training in neonatal resuscitation for medical staff participating in the Medical Emergency Team.

Action:

Neonatal Patient - Clinical Deterioration Management:
KPH Maternity staff complete the ENAMS Newborn Care (including neonatal resuscitation) mandatory education module via Intellilearn annually.
2014 KPH = 98%
2013 & 2014: PIPER (formerly NETS & PETS) education sessions on neonatal and paediatric resuscitation attended by KPH maternity staff.

Neonatal clinical deterioration:
* Treating Paediatrician called for advice or attendance
* Onsite Paediatrician, if consulting, called for assistance
* Emergency Department Physician (FACEM) called for assistance
* Paediatric / Neonatal anaesthetist called for assistance if available from Operating Room if necessary
* PIPER (Paediatric Infant Perinatal Emergency Retrieval service) is called for attendance if necessary

Neonatal resuscitation inclusive of intubation is a very skilled procedure and requires maintenance of skill competency in a variety of clinical scenarios. The current position is that the Met team medical staff are not required to be trained in neonatal resuscitation given the opportunity to maintain resuscitation / intubation until skilled medical practitioners are in available.

2014 December:
* Clinical Review Committee meeting. ACHS recommendation tabled for review and consideration for MET team / Paediatric / Emergency Department medical staff to attend NETS / PALS education and training for neonatal resuscitation. Outcome was for PIPER course to be investigated and further review medical staff training and support for neonatal resuscitation management.
* Contact made with PIPER regarding courses and no vacancy until after March 2015.
* Two course options are available: First response and Advanced (whole day including simulation training).

2015:
* PIPER Course conducted at Knox and attended by Midwifery staff and offered to Medical staff - Intensive care, Paediatrician and Emergency Department

2016:

PIPER (NETS) education on site for maternity staff and offered to Visiting Medical Staff who are rostered for the Met and Code Blue teams.
2016 September 14: 26 Maternity staff, 3 Emergency Medical Staff, 2 Intensive Care Fellows and 1 Paediatrician are enrolled to attend the course.

Completion Due By: June 2015

Responsibility: General Manager

Organisation Completed: Yes

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

In 2016 three emergency medical doctors, two intensive care doctors and one paediatrician attended along with 26 maternity staff.

There is ongoing review and regular training.

Standards Rating Summary

Organisation: Knox Private Hospital
Orgcode: 221485

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

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**

Standards Rating Summary

Organisation: Knox Private Hospital
Orgcode: 221485

Surveyor - NSQHSS V01

Core

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

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

Developmental

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

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

Combined

Standard	Not Met	Met	N/A	Total	Overall
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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**

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Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
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