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

Lady Davidson Private Hospital

North Turramurra, NSW

Organisation Code: 11 01 12

Survey Date: 23-25 August 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 four 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

Lady Davidson Private Hospital (LDOH) is a 115 bed private rehabilitation facility and is part of the Healthscope (HSP) Group. The hospital is a dedicated teaching hospital and one of the largest private rehabilitation hospitals in Australia. It is located at North Turramurra on Sydney's North Shore and sits within the Northern Sydney Local Health District which encompasses eleven Local Government Areas.

Services are provided for both DVA entitled and private patients and include fast stream rehabilitation, medical and palliative care, and a large Day Therapy Program/Outpatients Department. A Cancer Rehabilitation Program was commenced in March 2015 and is specially designed for those people with a primary diagnosis cancer post chemotherapy and radiotherapy to regain strength, mobility and stamina. Day therapy programs have also been expanded and community classes increased. A decrease in LDPH occupancy has occurred and is attributed to a substantial Increase in the number of available rehabilitation beds in the catchment area, both in the private and public sectors, and a reduction in referrals. Strategies are being undertaken to address this issue and include planned development of a specialty unit for orthopaedic spinal patients and increasing the focus on teaching and research.

The HSP National team provides support to the LDPH workforce through policies, guidelines and frameworks and opportunities to participate in relevant HSP Clinical Clusters, and benchmarking with other HSP Peer Group 5 dedicated rehabilitation hospitals. LDPH also benchmarks with the Australian Rehabilitation Outcomes Centre (AROC).

It is evident that the Executive and staff are striving for excellence in the standard of health care provided. A distinct focus is evident throughout the hospital on the engagement of the workforce in ensuring safe and quality patient-centred care is provided for consumers and in fostering partnerships with consumers and carers. Very good progress has been made in implementation of the National Safety and Quality Health Service (NSQHS) Standards. All core and the majority of the developmental actions are assessed as Satisfactorily Met (SM). Core actions 3.10.1 and 9.6.1 are assessed as fully met. There are a number of actions assessed as Met with Merit (MM). Developmental actions 3.19.2, 9.3.3 and 9.9.4 are assessed as Not Met and recommendations have been made. All the previous recommendations have been closed.

The Executive and staff are congratulated on their enthusiasm and achievements demonstrated during the survey.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Lady Davidson Private Hospital (LDPH) has an integrated system of governance that manages patient safety and quality. The structure and terms of reference of committees are clearly documented and show evidence of currency. The Quality and Risk Committee (QRC) and the Patient Care Review Committee (PCR) meet regularly, have standing safety and quality agenda items, and report to the LDPH Executive Committee. The Medical Advisory Committee (MAC) and the Consumer Advisory Committee (CAC) receive reports on LDPH safety and quality performance.

The systems for development and review of policies, procedures and clinical guidelines which are relevant to the operations of LDPH are undertaken at HSP Corporate and local levels. HICMR (Healthcare Infection Control Management Resources) policies are in use for infection control. Processes are well-established for ensuring currency of documents, legislative compliance and dissemination of information regarding alerts when legislative changes occur and for communicating new and revised policy documents to the workforce. Compliance with policies occurs via audits and incident monitoring. Accessibility to policy and procedure documents and clinical guidelines by end-users occurs via the HSP intranet and the LDPH L Drive.

Consideration of patient safety and quality of care is evident in LDPH strategic and operational plans.

A comprehensive range of quality and safety audits is conducted and supported with an audit schedule. A suite of safety and quality key performance indicators is used to monitor performance by the Quality and Risk, Patient Care Review and Executive Team committees and is incorporated in safety and quality reports which are subject to ongoing review. Clinical Quality KPI reports are regularly submitted to HSP Corporate and the National Safety and Quality Committee and performance is reported against identified targets and benchmarked with other HSP Hospitals. The survey team found that there are variable approaches to analysis of data and trending of performance related to LDPH audit results. The organisation is encouraged to strengthen these aspects to assist in identification of areas for improvement, development and implementation of follow-up action plans and monitoring of outcomes.

Position descriptions indicate workforce responsibilities for safety and quality. A LDPH organisation chart clearly outlines reporting lines and responsibilities of staff. Orientation, mandatory and in-service education programs provide information related to safety and quality responsibilities of the workforce and are provided via face to face education sessions and e-learning. The organisation reported that there is very low usage of agency staff. Processes for orientation of staff are well-developed and supported with educational resources. Evidence provided showed the level of workforce participation in orientation programs was 94% and 100% compliance of staff with the mandatory training programs. The organisation is congratulated on these achievements

The assessment of competencies of nursing and allied health staff are well-addressed.

The risk management system is overseen by the Executive and is supported with policies which provide the framework for risk management across the organisation, the use of RiskMan and staff education in risk management. The risk register incorporates clinical and corporate risks and reflects issues arising from incidents, inspections and reviews. There is evidence of risk rating, use of controls and risk mitigation activities, ongoing review and monitoring of outcomes.

The quality system is well-established and demonstrates very good linkage with the risk management system. Quality activities are comprehensively documented in the LDPH Safety and Quality Plan which is linked to the National Safety and Quality Plan. A wide range of quality improvements was demonstrated throughout the hospital. Examples include the LDPH Day Programs which have been subject to review, expansion and ongoing evaluation and the LDPH First Impression Project which has improved the quality of information provided to newly admitted patients.

Clinical practice

A comprehensive range of clinical guidelines is in use and a generic care plan is completed for all inpatients. Well-developed rehabilitation models of care are incorporated in inpatient and day programs and include completion of comprehensive assessments, goal setting, care planning and case reviews. Discharge planning commences at the

beginning of the episode of care and is very well-developed. Length of stay of all patients and variances against expected ALOS, mortality and morbidity data and AROC and ACHS clinical indicator data are subject to regular review by clinicians, the Quality and Risk Committee and Patient Care Review Committee, and the Executive.

The use of risk assessment tools is incorporated in the pre-admission assessments completed by Rehabilitation Assessment Nurses and in admission processes. Risk assessments include falls, malnutrition, pressure injury, and infection and cognitive status, allergies, VTE and medication and discharge risks. There is a clear exclusion policy regarding patients who should not be admitted to LDPH. Management plans are developed for patients identified at risk. Alerts are documented in the patient clinical record, the electronic administration information system, and in other communication tools. At-risk patients are discussed at clinical handover meetings. Audit results show generally good compliance with documentation of risk assessments and implementation of appropriate management plans. Action plans have been developed for areas identified as requiring improved compliance.

An effective system for escalating care is established and discussed more fully in Standard 9.

Hard copy integrated records and electronic pathology results are available at the point of care. A suite of policies provides the framework for management and documentation of patient clinical records. All patients have a unique identifier. Processes are well developed for checking for duplicate records, timely retrieval and tracking of records. Audit results show very good compliance with documentation requirements. The design of records allows for NSQHSS related audits to be completed. The sample of records checked by the survey team was generally well-documented.

Performance and skills management

Credentialling and defining scope of practice for medical officers occurs within the framework of the HSP By-Laws and LDPH clinical services capability and is overseen by the LDPH Medical Advisory Credentialling Committee. E-credentialling has been introduced recently and includes use of a database. HSP external credentialling audit results were reported to show 100% compliance.

AHPRA Registration of Medical Officers, nursing and allied health is subject to regular review. Appropriate processes for defining and monitoring the scope of practice of the nursing and allied health workforce are in use and include the use of position descriptions.

Policy and procedure are available for the safe introduction of new interventional procedures. Mechanisms for clinical supervision of registrars, nurses and allied health workforce and students are well-developed.

Performance review of medical officers includes monitoring working within approved scope of practice, incidents, clinical outcomes and conduct. Annual performance development and review are undertaken for other workers, with 92% compliance reported.

Incident and complaints management

The systems for management of incidents and complaints are well-developed and supported with policy/procedures and use of RiskMan. There is evidence of reporting, categorisation, risk rating and follow-up of incidents and complaints within target timeframes. Mechanisms are established for clinical review of Never Events and Sentinel Events, and as required provision of support by the National Risk Compliance Manager. Incidents are communicated to the workforce once confirmation and initial investigation have occurred. Monitoring of performance is overseen by the QRC and the Executive Team Committee. The organisation reported a very low level of incidents and complaints and a high level of compliments.

Application of the National Open Disclosure Standard is undertaken in association with investigation of incidents/complaints. Evidence was available showing that 93% of the clinical staff had completed e-learning Open Disclosure education.

Patient rights and engagement

Information regarding patient rights and responsibilities is consistent with the National Charter of Healthcare Rights and is available in the patient information directory, brochures, the HSP website and posters displayed throughout the facility, and is incorporated in the admission process. Access to interpreters is available. Results of the patient satisfaction surveys indicate high levels of patients understanding their rights and responsibilities.

Patients and carers are involved in the planning of treatment from the time of referral and assessment. Care plans

have provision for documentation of patient signature. Bedside patient care boards are in use in all clinical areas to facilitate communication and partnering with patients and carers. Results of patient satisfaction surveys show patients indicated they were involved in making decisions about their care.

Systems for management of financial consent are well-established and are subject to ongoing monitoring and audit. A separate consent form is used for blood transfusion procedures. Audits show very high compliance. Plans are in place for obtaining documented consent of patients in conjunction with the use of 'Wound Zoom' which is planned to be introduced in the future to assist with wound assessment management.

Information is provided to patients regarding completion of advance care directives and includes a comprehensive HSP brochure. Mechanisms are established for incorporation of alerts when patients present with an Advance Care Directive and when treatment limiting orders are established during a patient's episode of care. Advance Care Directives are not completed on-site by the LDPH workforce.

Hard copy clinical records are stored securely within the Medical Records Department on-site storage area with only Health Information staff and After Hours Nurse Managers able to access and distribute records. A privacy policy is available to the workforce and staff undertake privacy training. Access to all electronic information systems by staff is via restricted password protected procedures. Privacy and release of information protocols are made available to patients with evidence that they can access their health record information in a timely manner. Authorising procedures for use or disclosure of information outside the usual provision of care are well-established.

Data collected from LDPH Patient Satisfaction Surveys, HSP Patient Experience Surveys, complaints and compliments are used to gain feedback from patient experiences at LDPH and action plans are developed and improvements implemented as required. Results of the patient satisfaction survey 2015-2016 fourth quarter show patient satisfaction was 98%. Rehabilitation Day Programs 2015-2016 fourth quarter 95%. Results of the Patient Experience Survey 2015 showed 80% satisfaction. The LDPH workforce is congratulated on these achievements. The organisation is awaiting results of the survey which was completed from February to July 2016. An example of a quality improvement program being undertaken as the result of patient feedback is related to patient meals and food temperature.

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

LDPH demonstrates a distinct focus on fostering partnerships with consumers and carers. The governance arrangements occur within the framework of the HSP Partnering with Consumers Policy and are well-established. The Consumer Advisory Committee was established in 1997 and meetings are held quarterly. Membership includes Department of Veterans Affairs Contract Manager, representatives of veterans' organisations, War Widows Guild, the local community and a LDPH patient/consumer consultant. The committee is chaired by a CAC member and LDPH General Manager, Director of Nursing and Quality Manager are in attendance. Agenda items demonstrate emphasis is placed on the organisation's safety and quality activities with reports provided by the Executive. CAC members provide reports on their activities in the hospital and with their associated organisations and communities. Minutes of meetings are comprehensively documented. A Consumer Participation Plan has been documented detailing strategies to further increase consumer engagement in the organisation and includes proposed attendance of a consumer representative at the LDPH Quality and Risk Committee.

Participation of CAC members and patient/consumer consultants in the hospital activities is substantial and includes visiting patients, quality and safety activities and involvement in celebrations of significant events related to veterans and the hospital. Representatives of veteran organisations participate in ANZAC Day celebrations.

Consumer representatives have clearly documented position descriptions and schedules of activities which include visitation of patients and participation in safety and quality activities. Arrangements are established for new community representatives to participate in an LDPH orientation program. It is suggested that the organisation liaise with the newer consumer representatives to determine the effectiveness of the orientation to their roles and take follow-up action for any areas identified as requiring strengthening.

Evidence provided indicated that LDPH strategic planning activities incorporate feedback from consumers.

Evidence was available to demonstrate that the CAC members, consumers and carers have been consulted in the development and revision of publications/patient information materials to ensure that they are appropriate in content for the patients/carers, and are easy to understand and read. An example is the Patient Information Compendium which has been revised as a result of consumer feedback undertaken in association with the LDPH First Impression Project where it was established that staff provision of information was not meeting the needs of newly admitted patients. In recognition of the work being completed by Consumer and Carer Consultants across HSP a logo has been developed in consultation with consumers and is used to indicate a Consumer Approved Publication. Evidence was provided to demonstrate that feedback from the CAC, and consumers and carers, has been incorporated in publications.

Three MM ratings have been awarded in this criterion, in actions 2.1.1, 2.4.1 and 2.4.2.

Consumer partnership in designing care

Mechanisms for participation in designing and redesigning care are established. Activities have included involvement in the redevelopment of Lambert Ward and development of LDPH day programs.

Evidence provided showed that patient-centred care education is incorporated in orientation, mandatory e-learning and inservice education programs. Records show 100% participation of the workforce in the HSP Patient Centred Care e-learning program.

Evidence was provided to demonstrate that consumers provide education to the workforce through patient/staff forums which incorporate patient stories/experiences at LDPH. It is noted that the LDPH Consumer Participation Plan indicates that involvement of a consumer consultant in the LDPH orientation program is to be explored. The organisation is strongly encouraged to further develop strategies to ensure a more structured approach is used to demonstrate consumer participation in training of the LDPH workforce.

A Met with Merit (MM) rating has been awarded in this criterion, in action 2.6.1.

Consumer partnership in service measurement and evaluation

Mechanisms are established for provision of the community and consumers with information on the safety and quality performance of LDPH and includes presentation of reports to the CAC, and a display of information on the MyHealthscope website. It is suggested that LDPH quality and safety performance data be displayed throughout the hospital.

The LDPH Consumer Advisory Committee participates in measurement and evaluation of services and safety and quality performance. Patient/consumer representatives participate in quality activities. Examples include patient satisfaction surveys, and quality projects related to food services. It is suggested that additional quality projects could focus on “Way Finding” in the organisation.

Consumer partnership in service planning

Ratings

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

Action 2.1.1 Developmental

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

Surveyor Comment:

The governance arrangements occur within the framework of the HSP Partnering with Consumers Policy and are well-established. The Consumer Advisory Committee meets regularly and agenda items include the organisation's consumer engagement activities, safety and quality activities and review of performance. Minutes of meetings are comprehensively documented and show provision of reports by the Executive on LDPH activities and CAC members on their activities and those of the associated organisations and communities. A Consumer Participation Plan includes proposed attendance of a consumer representative at the LDPH Quality and Risk Committee. The survey team has assessed the level of achievement as MM.

Surveyor's Recommendation:

No recommendation

Action 2.4.1 Core

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

Surveyor Comment:

Evidence was available to demonstrate that LDPH CAC members, consumers and carers have been consulted in the development and revision of publications/patient information materials. The examples of publications provided demonstrated a high standard of compliance with prescribed criteria. The survey team has assessed the level of achievement as MM.

Surveyor's Recommendation:

No recommendation

Action 2.4.2 Core

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

Surveyor Comment:

Documented evidence was provided to demonstrate that feedback from the CAC, consumers and carers has been incorporated in publications. The survey team has assessed the level of achievement as MM.

Surveyor's Recommendation:

No recommendation

Consumer partnership in designing care

Ratings

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

Action 2.6.1 Core

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

Surveyor Comment:

Evidence provided showed that Patient Centred Care education is incorporated in orientation, mandatory e-learning and in-service education programs. Mechanisms are established for ongoing monitoring of workforce participation. Records show sustained high levels of workforce participation and at the time of survey showed 100% completion of the HSP Patient Centred Care e-learning program. The survey team has assessed the level of achievement as MM.

Surveyor's Recommendation:

No recommendation

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

Lady Davidson Private Hospital (LDPH) has a well-established governance framework which includes executive responsibility and a risk management approach which allows for the management and reporting of prevention and control of healthcare associated infections. Policies, procedures, protocols and monitoring systems are based on risk assessment and provide direction to assist in minimising infection risks to patients, carers and staff. The commitment to the prevention and controlling of healthcare associated infections (HAI) was evident across the organisation with a number of strategies being utilised. Strategies include input from the Healthcare Infection Control Management Resource (HICMR) program, Infection Prevention and Control Risk Management Plan and Audit Schedule. A proactive Clinical Nurse Consultant (CNC) Infection Control manages the infection control system with support from the Infection Control Committee. Composition of the committee includes a microbiologist and infectious disease physician. The role of the CNC would be enhanced if there were link nurses and/or infection control champions in each of the wards and therapy areas. Surveillance data that is appropriate for the organisation is collected and reviewed by the Infection Control Committee and the Patient Review Committee. Specific key performance indicators (KPIs) are reported to Healthscope (HSP). Annual review of hospital acquired infections is undertaken and trends are reviewed. Auditing allows for the monitoring of compliance and a comprehensive schedule is utilised.

Infection prevention and control strategies

A number of appropriate strategies are in place to allow for the prevention and control of healthcare associated infections and include a national hand hygiene program. Compliance with hand hygiene is monitored by the Infection Control Committee and is a (HSP) KPI. Compliance across all clinical departments and by other departments within the hospital groups is above the national average. Compliance is being driven by a Hand Hygiene Committee, a hand hygiene plan and hand hygiene auditors. Hand hygiene gel stations were evident throughout the facility, which the surveyors observed were well utilised by staff and visitors. The surveyors also observed that hand hygiene stations were able to be easily cleaned. Actions 3.5.1, 3.5.2 and 3.5.3 are rated Met with Merit (MM).

A comprehensive immunisation program is in place and includes a staff database which allows for the monitoring of staff immunisation status. There is infection prevention and control consultation related to occupational health and safety that ensures policies and procedures and/or protocols address the components of this action. There are Blood and Body Fluid Exposure Injury Toolkits to assist in the management of occupational exposures. Incidents are reported in RiskMan and trended data is monitored. A protocol is available to assist in the identification and management of occupational allergies. There is auditing of the workforce to ensure appropriate and competent use of personal protective equipment (PPE).

An invasive device audit has been completed and comprehensive competency-based learning packages are available for clinical staff. Review of compliance rates indicates a reasonable uptake by clinical staff. Monitoring of compliance across all other departments within the hospital is ongoing.

LDPH undertook a gap analysis in 2013 to identify procedures where clinicians would need to be efficient in aseptic technique. Subsequently a competency-based training package which is referenced to ANTT was implemented. There is ongoing monitoring by the education department and at the time of survey there was 100% compliance for medical and nursing staff. The Infection Control and Risk Management Plan identifies strategies to ensure competency of clinicians remains high and current. It is suggested that the risk management plan include actions for the management of possible new interventions that require aseptic technique and how to manage non-compliant staff. The actions 3.10.1, 3.10.2 and 3.10.3 are fully met and the surveyors agreed that the ratings for these actions be changed to Met with Merit (MM).

Managing patients with infections or colonisations

Standard and transmission-based precautions that are consistent with current national guidelines are in use. All patients are assessed prior to admission and staff have access to a precautions toolkit. Auditing of isolation practices compliance occurs along with audits of PPE compliance, hand hygiene and the environment, with data being reported

to the governing body and staff. There is recognition of the need to improve the management of equipment and signage to allow for improvement of the adherence to the use of transmission-based precautions.

Antimicrobial stewardship

The antimicrobial stewardship (AMS) usage policy supports the need to change antimicrobial prescribing habits with the aim of reducing unnecessary use of antimicrobials and promote the use of agents less likely to reduce resistance. Responsibility for oversight of the AMS policy lies with the Director of Medical Services and the Antimicrobial Stewardship Committee. The approach to AMS is multidisciplinary and there is access to expertise and resources of microbiologist, infectious disease physician, pharmacists and the infection control officer. Governance structure ensures that the outcomes are reported to the highest level of governance. Clinicians have easy access to therapeutic guidelines and clinical pharmacists are available and provide support to prescribers. An antimicrobial formulary identifies restricted, unrestricted and where infectious diseases physician input is required. A review of restricted antibiotics covering a three-month period has been undertaken and results have been circulated to all medical officers. Following an audit of oral antibiotics prescribing, changes to the AMS policy have occurred with a traffic light system in place to flag a review which is required after seven days. Anecdotal evidence indicates that there is good involvement of the infectious disease physicians. Changes have been made to antibiotic prescribing and they are no longer available via the imprest system. Monitoring of resistance is to commence and data is to be submitted to the National Antimicrobial Prescribing Survey (NAPS). Antibiograms are not available at this time; however this may become possible in the New Year.

Cleaning, disinfection and sterilisation

Maintenance and cleaning schedules are in place. Environmental auditing is undertaken with results indicating a high level of compliance. The surveyors suggest that an external environmental audit would be beneficial. The surveyors observed that the facility was clean and that storage rooms allowed for appropriate cleaning to occur. The surveyors suggest that one non-closed ice machine be removed to ensure that best practice is being met. An open ice machine is present in the therapy areas and is used for patient therapy only, and this machine is clearly signed. Alternatives could be considered. Inspection of the kitchen by the New South Wales Food Authority identified four issues which have been addressed. Linen is well-managed and the separation of clean and dirty is appropriate. Waste management is appropriate. The hydrotherapy pool parameters are measured and patients are screened prior to entry. There are no facilities for the reprocessing of reusable medical equipment, instruments and devices. All sterile stock are disposable items and there is a rotation system to manage expiry dates. While there is no reprocessing at LDPH there is a need for an action plan to address the requirements of AS4187 2014.

Communicating with patients and carers

Consumer specific information on the management and reduction of healthcare associated infections is provided to patients and carers. There has been no evaluation of the effectiveness of the information provided and a recommendation to address this action is to be found under action 3.19.2 in the body of the report.

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	MM
3.5.2	SM	MM
3.5.3	SM	MM
3.6.1	SM	SM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	MM
3.10.2	SM	MM
3.10.3	SM	MM

Action 3.5.1 Core

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

Surveyor Comment:

The Healthscope (HSP) Hand Hygiene Policy 8.10 has provided direction and support for the implementation of the Hand Hygiene Australia Initiative program at the Lady Davidson Private Hospital (LDPH) with compliance auditing and reporting over a long period of time. Reports are provided to HSP as part of a suite of key performance indicators and on MyHealthscope web site. Compliance rates are above the HSP target and for the last reporting period were 91.69% which is 5% above the current National Benchmark target. Breakdown by other departments other than clinical also indicated that compliance was above the target requirement. The survey team agreed that the proactive, well-established and sustained approach across LDPH for workforce compliance auditing is commendable and warrants this action to be re-rated to Met with Merit.

Surveyor's Recommendation:

No recommendation

Action 3.5.2 Core

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

Surveyor Comment:

Compliance rates from hand hygiene audits and staff training in hand hygiene have been regularly reported to the LDPH Executive in the Healthscope Infection Control Cluster, the Healthscope National Safety and Quality Committee and the Healthscope Corporate Executive. A long-established transparent system of benchmarking hand hygiene compliance rates internally and externally is remarkable. Since 2011 all facility results for hygiene compliance have been publicly reported on the MyHealthscope website. The LDPH overall compliance rate has consistently been higher than the National Benchmark. The survey team fully supports this action being increased to a Met with Merit rating.

Surveyor's Recommendation:

No recommendation

Action 3.5.3 Core

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

Surveyor Comment:

A number of proactive strategies are continuing to drive hand hygiene compliance. They include action items within the Infection Prevention and Control Risk Management Plan, eLearning program completed annually by all staff, patient survey to assess workforce compliance and two Gold Standard auditors. The survey team fully supports this action being increased to a Met with Merit rating.

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

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

Surveyor Comment:

The HSP Aseptic Procedure Preparation Policy 8.38 has provided direction and support for the implementation of aseptic training assessment and monitoring. LDPH undertook a gap analysis in 2013 to identify procedures where clinicians would need to be proficient in aseptic technique. An education and competency package that is referenced to ANTT is utilised. At the time of survey compliance was 100% for medical and nursing staff. The survey team fully supports this action being increased to a Met with Merit rating.

Surveyor's Recommendation:

No recommendation

Action 3.10.2 Core

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

Surveyor Comment:

Compliance with aseptic technique is monitored monthly by the education department and reported at the Hand Hygiene Committee. Surveillance data for Hospital Acquired Infections associated with procedures that require aseptic technique are collected. The survey team fully supports this action being increased to a Met with Merit rating.

Surveyor's Recommendation:

No recommendation

Action 3.10.3 Core

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

Surveyor Comment:

Compliance with aseptic technique is monitored monthly by the education department and reported at the Hand Hygiene Committee. Surveillance data for Hospital Acquired Infections associated with procedures that require aseptic technique are collected. The survey team fully supports this action being increased to a Met with Merit rating.

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	NM

Action 3.19.2 Developmental

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

Surveyor Comment:

Patient infection prevention and control information has not been evaluated to determine if it meets the needs of the target audience.

Surveyor's Recommendation:

Patient infection prevention and control information be evaluated to determine if it meets the needs of the target audience.

Risk Level: Low

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The Drug Advisory Committee (DAC) is responsible for overseeing drug and therapeutic activities. Related committees are the Medical Advisory Committee and HSP Medication Cluster Committee. The DAC meets regularly and membership includes LDPH Director of Medical Services, Director of Nursing, Senior Career Medical Officer, a LDPH Clinical Pharmacist, and a pharmacist from Hospital Pharmacy Supplies (HPS) which is the organisation contracted to provide pharmacy services at LDPH. Two LDPH clinical pharmacists are on-site five days per week and undertake medication reviews, and provide education to the medical and nursing workforce and patients.

HSP and LDPH policies/guidelines are available to support safe medication management and show evidence of ongoing review. The medication authority system and audit schedule evidence showed that 84% of nursing staff had completed mandatory medication safety e-learning. Audits include MSSA, CEC Indicators for Quality Use of Medicines in Australian Hospitals and National Medications Chart drug registers. A notable improvement made is the revision and implementation of the National Inpatient Medication Chart (NIMC) to cover a 35 day period for use by rehabilitation patients and which was reported to have reduced transcription errors. This chart has been adopted in all other HSP rehabilitation hospitals. A document with reminders for safe medication management has been developed by the Director of Medical Services and is being issued to medical staff in conjunction with the doctors' handbook and is deemed to have contributed to a reduction in medication errors.

Documentation of patient information

Policies are available to support the clinical workforce in documenting accurate patient medication records. NIMC and medical documentation audit results show good levels of compliance with recording the patient medication histories and allergies. Policies and procedures are in place for recording and reporting adverse drug reactions, including notification of the TGA. Mechanisms to monitor events includes use of the incident reporting system. Medication incidents are entered in RiskMan and subject to investigation and follow-up with the LDPH workforce. Performance is monitored by the DAC, Quality & Risk Committee and MAC. Nil significant adverse reaction events and nil sentinel events were reported. Learnings from LDPH incident investigations and from the HSP Medication Cluster Committee are communicated to LDPH clinical staff.

Medication reconciliation occurs on admission and on separation of patients and is undertaken by nurses and medical officers and oversighted by clinical pharmacists. HSP Medication management plan has been modified for LDPH use and is awaiting Corporate approval. Audit results August 2016 showed there is a need for improved documentation of medication histories and reconciliation on admission. Audit results April 2016 identified that there is a need to increase documentation of VTE Risk assessments and improve documentation of telephone medication orders within required timeframe. The organisation is encouraged to implement the action plans to address these areas.

Medication management processes

Electronic and hard copy references are available to support medication practice. Clinical Pharmacy staff support the medical and nursing workforce, assisting with education in response to particular needs as well as in provision of ongoing programs. Medication storage and distribution systems are generally well-managed and appropriate mechanisms are in use for disposal of unwanted, unused and expired medications. Patients' own medications including Drugs of Dependence (DDs) brought in to hospital are stored, used, accounted for or disposed of with their permission. Bedside lockable drawers are available for storage of patient medications, excluding DDs, which are stored in secure drug cupboards. Audits of DD registers are undertaken and good compliance with required documentation was reported.

LDPH has a high risk (PINCH) medication policy and list. Posters are present in the secure treatment rooms to identify (PINCH) drugs. Potassium chloride ampoules are not held in any treatment rooms. Hydromorphone is stored in clear pink trays in DD cupboards; however alerts were not being used to identify anticoagulants and insulins stored in locked cupboards and drug fridges in treatment rooms. It is strongly suggested that the use of coloured containers and TallMan lettering be implemented to assist in identification and management of all high risk drugs.

Storage of temperature sensitive drugs in wards occurs in bar fridges and monitoring of temperatures is undertaken daily. The survey team strongly encourages the proposed replacement of the fridges with designated drug fridges with in-built alarms.

Continuity of medication management

Medications on admission, internal transfer and discharge are supported with specific policies and are well-managed. A tool is used to communicate medications and changes to medications in the clinical handover of patients. Discharge medication profiles are prepared by clinical pharmacists. All patients are given a medical discharge summary for their GP which includes a list of medications.

Communicating with patients and carers

Medication documented information is available for provision to patients. Improvement of materials was reported as a result of patient feedback. There was evidence of improved documentation of medication management plans.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The LDPH patient identification system is overseen by the Patient Care Review Committee and the Executive Committee. Policies, procedures and protocols are designed to ensure the correct identification of a patient at any point in time during admission or course of treatment and apply to inpatient and outpatient settings. The four approved identifiers include: MRN, name, date of birth and gender and are used at the time of admission or registration, when care or other services are delivered, at the time of clinical handover, patient transfer or discharge. The patient identification band and day program stickers meet national specifications. Auditing of compliance has occurred for both inpatients and day program patients and an action plan is currently addressing some minor identified issues.

Processes to transfer care

Patient identity is confirmed using three patient identifiers when transferring responsibility of care. Observation of the clinical handover process demonstrated effective use of the identification band.

Processes to match patients and their care

Events that require patient procedure matching are clearly identified within HSP policy, procedure and protocol and are used to guide practice in ensuring patients are matched to their intended procedure, treatment or investigation. This policy applies to all invasive diagnostic and treatment procedures including radiology. Auditing of compliance occurs and incidents, if and when they occur, will be recorded in the incident database RiskMan. Patient identification errors are a HSP KPI and LDPH is within the target range.

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

LDPH has implemented an organisation-wide system to ensure that there is a structured approach to clinical handover that is relevant to the health service. There is a comprehensive procedure in place which covers all clinical disciplines, as well as agreed tools and processes relating to clinical handover. The agreed handover tool uses the ISOBAR format. There has been monitoring of the effectiveness of the process with oversight of the Standard being undertaken by the Patient Care Review Committee.

Clinical handover processes

The clinical handover process is appropriate for the health service and involves all clinical staff. The clinical handover process clearly identifies the location of where the handover will occur, involvement of clinical staff, the need for effective communication of current care requirements and the involvement of patients and/or career in the process. Auditing of the process has been undertaken and includes feedback from clinicians and patients. Changes that have resulted include the introduction of second nursing clinical handovers each day. It is suggested that the medical officers document their handover discussion.

Patient and carer involvement in clinical handover

The surveyors observed clinical handover at LDPH and noted that it was undertaken in a professional manner. There was good interaction with patients, in that they were included in the discussion about their current and ongoing care. Reconciliation of identification, medicines and intravenous therapy occurred at this time. There are mechanisms to involve patients and/or carers in clinical handover such as the use of bedside patient white boards and the provision of patient written information on 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

Blood and blood product policies, procedures and/or protocols are evidence-based and include pre-transfusion practices, prescribing and clinical use and the red blood cell audit monitors compliance. Results of the audit identified poor documentation in the clinical record. A sticker which is a documentation checklist is currently being placed in the clinical record. LDPH has identified that due to the low numbers of blood transfusion there is a need to ensure that risk minimisation strategies are in place. These include a blood transfusion pack in the ward areas to provide staff with easy access to the process. This pack contains a comprehensive checklist to assist staff in the process of blood transfusion. BloodSafe eLearning is a mandatory yearly requirement and compliance is monitored by the staff educator. Incidents and adverse events are reported in the incident management system RiskMan. Haemovigilance activities are reported at state and national levels.

Documenting patient information

There is some information documented in the patient clinical record regarding transfusion of blood. The need to improve this documentation has been identified to ensure that past transfusion history as well as current medical history, indications for transfusion, special requirements, type and volume of product transfusion and patient responses to transfusion are effectively documented.

Managing blood and blood product safety

There are processes and systems in place to ensure the safe and efficient receipt, storage and transport of blood and blood products and that there is nil wastage. Systems for cold chain integrity, sample collection, cross-matching, product collection and inventory management including storage, handling and transport are monitored to identify and address weak spots that increase the risk of human error and handling, and any subsequent patient harm or wastage. Auditing of both the blood register and blood refrigerator maintenance is undertaken. Temperature monitoring occurs and there is appropriate documentation of same. The blood refrigerator is locked.

Communicating with patients and carers

Information is provided and is available in other languages, and readily available for clinicians. Currently the care plan is fragmented and the surveyors suggest that this be reviewed and ensure that there is evidence of patient and/or carer involvement. Consent compliance is audited and results indicate high compliance.

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

There are well-established governance structures in place, with clear policies and procedures based on the Pan Pacific Clinical Guidelines for the Prevention and Management of Pressure Injury. Auditing monitors compliance with the completion of the Waterlow score as per policy and the timely provision of pressure relieving devices. Pressure injuries are reported in the incident management system RiskMan. This data is able to identify prevalence, the severity of the injury and if the injury was present at the time of admission or hospital acquired. Education in the form of an eLearning package, 'Pressure Ulcer Basics' has been completed by a reasonable number of staff.

Preventing pressure injuries

Patients are screened on presentation using the pressure injury risk assessment/management tool which includes skin assessment, and pressure injury strategies are implemented as required. Nutrition (Malnutrition Screening Tool) is part of the assessment process and referral occurs to dietetics if required. The surveyors suggest that LDPH review its current assessment tool to ensure that the process and tools reflect evidence-based best practice.

Managing pressure injuries

There is an evidence-based wound management system which is consistent with best practice guidelines that includes protocols and processes for patient care when a pressure injury is identified. The current wound assessment and management plan is under review. While this assessment form includes management of pressure injury pain, assessment would be more effective if a best practice pain assessment tool was utilised. A random sample to assess pressure injury documentation compliance with wound management plans has recently been completed. Issues that have been identified are part of a quality action plan to improve compliance and patient outcomes.

A Met with Merit (MM) rating is awarded in action 8.8.1.

Communicating with patients and carers

Patients and carers are provided with pressure injury prevention brochures and discussion occurs at this time. Pressure injury management plans are developed in partnership with patients and carers, which is reflected in the patient satisfaction survey results.

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	MM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

Action 8.8.1 Core

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

Surveyor Comment:

There is an evidence-based comprehensive wound management system which is consistent with best practice guidelines and describes the protocols and processes for patient care once a pressure injury has been identified. Policies and procedures refer to Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury. Clinical staff have access to a wound Clinical Nurse Consultant. The survey team fully supports this action being increased to a Met with Merit rating.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The Director of Nursing and the Director of Medical Services have governance responsibilities for the development, implementation and maintenance of the organisation's recognition and response system. A comprehensive documented policy/procedure provides the framework for implementation of recognition and responding to clinical deterioration system and includes a comprehensive flow chart which provides directions for staff. All deaths and cardiac arrests are reviewed by the Director of Medical Services. Data collected about the response and recognition system is reviewed by the Quality and Risk Committee and the Medical Advisory Committee with feedback to the clinical workforce. There is ongoing education to assist with ongoing improvement of the system.

Recognising clinical deterioration and escalating care

A general adult observation chart is used to measure and document observations. The adult observation chart incorporates a track and trigger system which is designed on human factor principles and comprises trigger ranges for vital signs. A basic audit of observation charts has occurred but there is recognition that this audit tool needs to be strengthened.

Responding to clinical deterioration

There are track and trigger responses incorporated in the observation chart which are used to escalate concern when observation parameters are outside normal parameters. When concerns are identified processes include discussion with the senior nurse, and notification of the visiting medical officer. In the event of a code blue, trained nursing staff can initiate basic life support and call an ambulance requesting a paramedic and the appropriate visiting medical officer. Review of the nursing staff and visiting medical officer database indicated that staff complete mandatory basic life support training and competency assessment is at 100%. Action 9.6.1 is fully met and is the subject of a Met with Merit (MM) rating. Monitoring and review of the outcomes of code blue calls occurs.

Communicating with patients and carers

Patients, families and carers are provided with a brochure which outlines how to access assistance if concerned about changes in the patient condition. A not-for-resuscitation form is currently available and it has been recognised that this form needs to be revised and this has commenced. It has been identified that there is a need to have a system to encourage patients to complete advance care directives. Patients who present with advance care directives or limited treatment orders have this information documented in their clinical record. Information for family escalation of care has only recently been introduced and therefore there has not been time to review the performance and effectiveness of the process and the SM ratings for 9.9.3 and 9.9.4 have been changed to NM.

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	MM
9.6.2	SM	SM

Action 9.6.1 Core

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

Surveyor Comment:

LDPH is a sub-acute facility that has limited access to after hours' medical coverage. Basic Life Support training is a yearly mandatory competency and part of the orientation program for staff. Compliance is maintained and monitored by the staff educator. Compliance of front line staff is 91.3%. The survey team fully supports this action being increased to a Met with Merit rating.

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	NM
9.9.4	SM	NM

Action 9.9.3 Developmental

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

Surveyor Comment:

The performance and effectiveness of the system for family escalation of care has not been reviewed.

Surveyor's Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Risk Level: Low

Action 9.9.4 Developmental

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

Surveyor Comment:

As there has been no evaluation of family escalation of care, no actions to improve the system have occurred.

Surveyor's Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Risk Level: Low

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

The LDPH Quality and Risk Committee oversees the development, implementation and evaluation of the falls prevention and management program. A falls prevention policy provides the framework to support the reduction in falls and to minimise harm from falls. Falls incidents are reported in RiskMan and are investigated. Some trended data is available and there is recognition of the need to further investigate all incidences of patient falls. A quality improvement project has commenced with data being collected to allow for comparison with peer groups within HSP. Review of ACHS Clinical Indicator data indicates that LDPH data is significantly different from other organisations. Equipment and devices are available to assist in falls prevention.

Screening and assessing risks of falls and harm from falling

Patients are screened using a falls risk assessment tool prior to admission, at the time of admission and thereafter as required. There is a multidisciplinary approach to falls prevention with allied health utilising a number of discipline specific assessment tools. Auditing indicates a high level of documentation compliance. As part of the proposed quality project it would be useful to review the screening and assessment tools that are currently in use to ensure that they are meeting best practice.

Preventing falls and harm from falling

Care plans are developed in accordance with patient identified risks and history of falls. Currently this documentation is fragmented and a review of the current documentation process would be beneficial. The surveyors suggest that there is a need to have a multifactorial falls prevention and harm minimisation plan that reflects best practice in the clinical record. There is some monitoring of the effectiveness and appropriateness of falls prevention plans but this process needs to be strengthened. Patients who are at risk of falling are identified as part of the clinical handover process, flagged on the patient journey board and identified on the patient bedside whiteboard. Patients and cares are provided with a discharge summary that indicates if ongoing follow-up is required.

Communicating with patients and carers

LDPH recognises that there is a need as part of the rehabilitation process to provide information for patients and carers to assist in the prevention of falls. A number of brochures and booklets are available for patients and carers. The occupational therapist provides regular falls prevention talks to 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	MM
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	MM
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	MM

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	MM
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	MM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	MM
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	MM
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	MM
3.10.2	Compliance with aseptic technique is regularly audited	SM	MM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	MM

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	NM

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	MM
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	MM
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	NM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	NM

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: Preventing and Controlling Healthcare Associated Infections
Item: 3.19
Action: 3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience

Surveyor's Recommendation:

Patient infection prevention and control information be evaluated to determine if it meets the needs of the target audience.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Item: 9.9
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Surveyor's Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Item: 9.9
Action: 9.9.4 Action is taken to improve the system performance for family escalation of care

Surveyor's Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Recommendations from Previous Survey

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

Recommendation: NSQHSS Survey 1013.2.4.2

Recommendation:

Continue to maintain documentation of consumer and carer feedback which is used in the preparation of patient publications.

Action:

- Participation in Patient Centred Care Experience Survey on a yearly basis- results collated by the National Quality Team.
- Quarterly Community Advisory Committee established in 1997 and has been active for the past 17 years. Committee is evaluated and participants provide feedback via surveys
- In house Patient Experience Surveys conducted quarterly, feedback tabled, discussed and actioned from the Quality and Risk Meetings and CAC meetings.
- Focus Group conducted in February 2013 and another planned for 2015.

Self Assessment Progress Report September 2015

- The Community Advisory Committee has reviewed the Information Package provided to patients on admission to LDPH in late 2013-nil have changed since then
- In the Development of the Cancer Rehabilitation Brochure for the launch in March 2015, participants of the Day Therapy program were requested to review the draft for photos, colour scheme, language and content by the Marketing Manager
- Healthscope produced generic brochures are reviewed by the Corporate Consumer representative group and from mid 2015 will have a symbol purposely printed on them as seen in "**myhealthscope"*-attempted to attached to documented without success***
- As of September 2015, LDPH is recruiting for a Patient Representative(s) for general rehabilitation and oncology rehabilitation who will assist with review of patient information documentation as well as be part of the Quality and Risk Meeting forums.

Self Assessment for Survey August 2016

- LDPH has recruited two Consumer Consultants in December 2015
- One has since resigned but another has been recently recruited and will begin the month of survey
- One of the Consumer Consultants participates on the Community Advisory Committee, Has reviewed the Patient Information Package which includes Day Therapy information =18 Brochures.
- This includes Escalation of care for patients and carers as well as Clinical bedside handover brochures.
- Marketing Co -ordinator in the process on updating the in house information with the Consumer Approved logo
- The Community Advisory Committee continues to receive an update in the Quality Program and Business Activity which includes current Strategic Plan information on a quarterly basis.
- The site map is provided within the Information Package and is displayed within the main corridor and has improved in labelling.

Completion Due By: December 2015

Responsibility: General Manager

Organisation Completed: Yes

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

Evidence was available to demonstrate that documentation related to feedback from the Consumer Advisory Committee, and consumers and carers, was being maintained and had been incorporated in LDPH publications and information materials developed for consumers and carers.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care

Recommendation: NSQHSS Survey 1013.2.6.1

Recommendation:

Continue to facilitate the needs of individuals and engage them in the planning of their care and include family members and carers.

Action:

- Patient Centred Care E Learning Package has been developed by Healthscope National Office Quality Team. It is Mandatory for all staff to undertake
- Corporate Educator in PCC available for on site education of staff
- Communication Boards installed in all patient's rooms- a survey of patients conducted at LDPH- trend positive from responses and lesson learnt from staff to update them on a regular basis.
- Rehabilitation Case Management Plan document update to include more family and carer participation in decision making of the future care of patients
- Volunteer program to still to be launched in 2015 and will be advertised in local press- large demographics of Lady Davidson Private's case mix.
- Advance Care Directive publication provided by Healthscope in 2014 "Advance Care Planning, Make the Choice....Experience the Difference"

Self Assessment Progress Report September 2015

- As LDPH has a rehabilitation focus all patients admitted for a program has a Patient Management Plan (PMP) developed. This is utilised at Case Conferences that occur weekly during admission
- The development of the PMP is the responsibility of the Visiting Medical Officer and is completed and signed with goals and related reports from the multidisciplinary team that attends the Case Conference.
- It includes sections to document when the family or carer are involved or questions to be asked and when necessary, the patient themselves attend the Case Conference.
- Regular attendees are the VMO, Rehab Registrar, NUM or a nursing representative, allied health physio , OT , Speech Therapist, Social Worker or Dietitian. On request the pharmacists or dieticians can attend.
- It has a checklist on the front page which includes Key Risks/Issues such as Falls Risk, MRO, Pressure Injuries, Anticoagulants, C Diff, VTE risk, Nutrition

- The plan was extensively reviewed and updated by the Medical Director, VMOs, Clinical Staff and Quality Manager in early 2015. It is specific to LDPH Form MR 008
- Health Insurance funds can request an audit of these plans on a regular basis of their inpatient customers

Self Assessment For Survey August 2016

- The E Learning Package of Patient Centre Care remains a mandatory requirement for staff at Lady Davidson Private Hospital
- Compliance for 2016 up until the end of July is over 84% that has undertaken the mandatory training which includes employed medical officers
- Healthscope Policy 10.05 2016 update Consumers Partnering with
- Healthscope Policy 10.09 Case Conference Rehabilitation is available to the multidisciplinary team at LDPH as well as HSP Policy 10.01 Discharge Planning
- Allied Health undertake Home Visits with patients where appropriate and are guided by HSP Policy 10.02 Home and Community Visits
- Nursing staff request that the patient sign their Ward Plan on commencement in that they are in agreement of the plan drawn up in consultation with them or their family member/carer.
- In the Patient Centred Care Survey results respondents indicated an improvement of 13% in responsiveness of staff from 2014-2015; an improvement of discharge information of 4% from 2012-2015

Completion Due By: June 2015

Responsibility: Medical Director

Organisation Completed: Yes

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

Patients and carers are involved in the planning of treatment from the time of referral and assessment. Care plans have provision for documentation of patient signature. Bedside patient care boards are in use in all clinical areas to facilitate communication and partnering with patients and carers. Results of patient satisfaction surveys show patients indicated they were involved in making decisions about their care. The recommendation is closed.

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

Recommendation: NSQHSS Survey 1013.3.10.1

Recommendation:

As this is a Transitional Arrangement in place until 31 December 2015, ensure the risk analysis, plan and training are kept up to date.

Action:

- Undertaken by the Clinical Nurse Consultant in liaison with HCMIR
- Discussed at length in the Infection Control Clinical Cluster

Self Assessment Progress Report September 2015

- Healthscope has a Transitional Arrangement concerning competency with aseptic technique with medical staff
- LDPH Clinical Staff have a Mandatory Competency yearly, with a tracking spreadsheet from January - December
- Compliance YTD 2015 for staff 62 % with 4 months available for remainder to undertake.
- MM rating in 2013 was correct, medical staff were included in this competency in 2013, the Infection Control CNC has been here long term and well respected by VMO, they are very compliant to her suggestions

Self Assessment for Survey 2016

- ANNT Practical is mandatory for all nursing clinical staff and allied health according to tracking spread sheet compliance sits at 91% as of end of July with expected compliance at 100% by survey date. This is an increase in compliance since 2015
- Practical competency for registrars, Career Medical Officer + Medical Director for IV cannulation, Basic Dressing Technique, and Hand Hygiene, Antimicrobial Stewardship at 100% compliance for 2016- Competency observation undertaken by Infection Control CNC
- Risk Analysis undertaken for aseptic technique training and meeting requirements for medical officers
- Infection Prevention and Control Care plan updated May 2016 for management of patients with known MROs on admission and those identified whilst an inpatient
- June 2015- Information Sheet received from HICMR on Carbapenem -Resistant Enterbacteriaceae (CRE)
- ANTT practical training on the education calendar for clinical staff notice

Completion Due By: Dec 2014

Responsibility: Staff educator and NUMs

Organisation Completed: Yes

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

The Infection Prevention and Control Risk Management Plan ensures that the risk analysis, plan and training are kept up-to-date. Therefore the intent of this recommendation has been met and the recommendation is closed.

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.2 Compliance with aseptic technique is regularly audited

Recommendation: NSQHSS Survey 1013.3.10.2

Recommendation:

Ensure that the schedule for assessment of monitoring aseptic technique, which is part of a Transitional Arrangement in place for 2013 and beyond, is ongoing.

Action:

- As per previous recommendation

As per previous recommendation -Self Assessment Progress Report September 2015

Healthscope has a Transitional Arrangement concerning competency with aseptic technique with medical staff LDPH Clinical Staff have a Mandatory Competency yearly, with a tracking spreadsheet from January -December Compliance YTD 2015 for staff 62 % with 4 months available for remainder to undertake.
MM rating in 2013 was correct, medical staff were included in this competency in 2013 , the Infection Control CNC has been here long term and well respected by VMO , they are very compliant to her suggestions

Self Assessment for Survey 2016

- ANNT Practical is mandatory for all nursing and allied health clinical staff according to tracking spread sheet compliance sits at 90% and expected to reach 100% by survey in late August
- Practical competency for registrars, CMO + Medical Director IV canalisation, Basic Dressing Technique, and Hand Hygiene, Antimicrobial Stewardship at 100 % compliance for 2016- Competency observation undertaken by Infection Control CNC
- Risk Analysis undertaken for aseptic technique training and meeting requirements for medical officers
- Infection Prevention and Control Care plan updated May 2016 for management of patients with known MROs on admission and those identified whilst an inpatient
- June 2015- Information Sheet received from HICMR on Carbapenem -Resistant Enterbacteriaceae (CRE)
- ANTT practical training on the education calendar for clinical staff notice

Completion Due By: Dec 2014

Responsibility: Staff Educator + NUMs

Organisation Completed: Yes

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

The Infection Prevention and Control Risk Management Plan ensures that there is monitoring of aseptic technique. Therefore the intent of this recommendation is met and it is closed.

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.3 Action is taken to increase compliance with the aseptic technique protocols

Recommendation: NSQHSS Survey 1013.3.10.3

Recommendation:

Ensure that the action plan for improving clinician aseptic technique remains ongoing.

Action:

- As per previous two recommendations

As per previous two recommendations-Self Assessment Progress Report September 2015
Healthscope has a Transitional Arrangement concerning competency with aseptic technique with medical staff LDPH Clinical Staff have a Mandatory Competency yearly, with a tracking spreadsheet from January -December Compliance YTD 2015 for staff 62 % with 4 months available for remainder to undertake.

MM rating in 2013 was correct, medical staff were included in this competency in 2013 , the Infection Control CNC has been here long term and well respected by VMO , they are very compliant to her suggestions

Self Assessment for Survey 2016

- ANNT Practical is mandatory for all nursing clinical staff according to tracking spread sheet compliance sits at 73 % with 4 months of the year remaining
- Practical competency for registrars, CMO + Medical Director IV canalisation, Basic Dressing Technique, and Hand Hygiene, Antimicrobial Stewardship at 100 % compliance for 2016- Competency observation undertaken by Infection Control CNC
- Risk Analysis undertaken for aseptic technique training and meeting requirements for medical officers
- Infection Prevention and Control Care plan updated May 2016 for management of patients with known MROs on admission and those identified whilst an inpatient
- June 2015- Information Sheet received from HICMR on Carbapenem -Resistant Enterbacteriaceae (CRE)
- ANTT practical training on the education calendar for clinical staff notice

Completion Due By: Dec 2014

Responsibility: Staff Educator and NUMs

Organisation Completed: Yes

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

The Infection Prevention and Control Risk Management Plan ensures that the risk analysis, plan and training are kept up-to-date. Therefore the intent of this recommendation has been met and it is closed.

Standard: Medication Safety
Criterion: Governance and systems for medication safety
Action: 4.5.1 The performance of the medication management system is regularly assessed

Recommendation: NSQHSS Survey 1013.4.5.1

Recommendation:

Review the medication management system as a whole.

Action:

- Medication Management System at LDPH is the responsibility of professionals that are proactive in the maintenance of a safe environment for the patient as well as provision of a professional approach to staff that includes education and the identification of incidents and hazards that arise.
- LDPH has a Team of Clinical that review all the patients medication charts and MMP that are undertaken on admission by nursing staff, monitor compliance to therapies ordered and educate patients for preparation for discharge as well as liaising with the patient's community pharmacists.
- LDPH has a Script tracking system in place with the dispensing pharmacy on site and will eventually has an electronic ordering script system connected.
- Certain Scheduled drugs are ordered and delivered under strict control procedures under the responsibility of the drug licensee, Director of Nursing.

- The central supply/store of scheduled drugs are accounted for daily by the DON or her representative as well at Ward level each shift
- A study or audit of the journey of medication management within LDPH will be considered by the Medication Safety Committee in 2015.
- LDPH participates in the NIMC audit with CEC and has actioned deficiencies when identified.
- Medication Incidents are reported and reviewed, TGA reporting is managed by the Clinical Pharmacists, and Quality Manager under direction of the Medical Director.
- LDPH implemented a Long Stay Medication Chart over the last months on 2013 and early 2014 that is compliant with the National Medication Chart.

Self Assessment Progress Report September 2015

- The Executive Team member responsible for Medication Safety at LDPH is the Director Of Nursing.
- The Director of Nursing chairs the Drug Committee (Medication Safety) with membership that includes the Medical Director, Employed Career Medical Officer as well as the Clinical Pharmacist, Pharmacists from HPS, NUM and the Quality Manager. Co operated when necessary is the Staff Educator.
- The Director of Nursing (DON) holds the Drug Licence as well as maintaining the role of distribution of schedule drugs to the wards and management of the hospital drug safe. They undertake the ordering and delivery acceptance of these substances to the premises in liaison with the Nurse Unit Managers and Stores Manager.
- The DON reviews/monitors the imprest orders and its expenditure on a monthly basis with direct reporting on the matter to each cost centre to the General Manager. These reviews include antibiotic usage and type of antibiotic utilised in patient care and which VMO has ordered which antibiotic.
- The DON is a committee member of the Infection Control Committee that meets every second month where antibiotic stewardship is a permanent agenda item and a report is provided.
- An Antibiotic Stewardship audit is **conducted by the Clinical Pharmacists and Infection CNC 6 Monthly. The report is forwarded to the Medical director, tabled at Infection Control Committee and Patient Care Review Committee.**

Self Assessment for Survey August 2016

- Medication Safety Self Assessment Audit (CEC) has be undertaken - awaiting results and an action plan will be established once results received.
- A process chart is available for the pathway of Schedule 8 and Schedule 4 drugs for their journey from order to delivery to ward available with local policy support
- A flow chart is available for imprest medications from order to cupboard storage with a supporting local policy
- A flow chart for individual prescriptions order from HPS (pharmacy) to delivering to the patient and ward is available with supporting local policy available for staff to view on "L" drive /Policy/Clinical
- Education planned with Medication safety is planned and advertised in monthly calendar.
- Within the Patient Centred Care survey results LDPH staff has improved on the patient's management of pain from 2013 to 2014 and 2015
- Audit Results tabled at Drug Committee (medication Safety) and are followed up accordingly with the Medical Director addressing issues with ordering and documentation with antibiotics, VTE documentation and Adverse Drug Reaction -Alert Sticker directly with the registrars
- Healthscope provides an extensive package of policies surrounding the management of medications and for guidance to staff.

Completion Due By: Clinical Pharmacists /medical director

Responsibility: Clinical Pharmacist and Quality Manager

Organisation Completed: Yes

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

There was evidence that the medication management system has been subject to review. Audits include MSSA, CEC Indicators for Quality Use of Medicines in Australian Hospitals and National Medications Chart, drug registers.

MSSA indicators 2013-2016 showed improvement in a number of areas including patient information (21%), medication information (4%), environmental factors, workflow and staffing patterns (5%). Follow-up actions plans were implemented for areas identified as requiring improvement.

Standard: Medication Safety
Criterion: Continuity of medication management
Action: 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

Recommendation: NSQHSS Survey 1013.4.12.4

Recommendation:

Ensure medical and nursing staff clinical handover utilise the MMP (Medication Management Plan) and medication chart to increase clinician checking and potentially reduce medication errors.

Action:

- As per previous recommendation
- NIMC Audit undertaken in September 2014, LDPH were compliant in utilization at 97.5% of audited patients MMP charts and notes. National Average below 70%

September 2015 Self Assessment Progress Report

- Medication Incidents are reported in the RiskMan Data System
- These are automatically forwarded to the NUM of the individual ward by the system for review and action with staff if necessary-these include MMP non reconciliation reports.
- The NUM and After Hours Managers have been provided with a yearly report from the Indicator Set July - July 2014-June 2015
- If incidents relate to the Medical Staff the QM or Clinical Pharmacists forwards the incident to the medical director for review and education follow up with the registrar group (Meets every Thursday)
- Since Early 2013 RiskMan Extension facility addressing eight of the Ten National Standards is available. Medication Safety is one of the indicators available for review
- A detailed advanced report as well as an indicator report is reviewed by the Medication Committee pre meeting circulated by the Quality Manager. Areas of concern are discussed at the meeting
- This advanced report provides details on Incident Date/Time ID, Gender, Age, Details of incidents, Investigations and Findings, Controls implemented, Outcome, Location and Specialty
- An indicator report is also reviewed with indicators collected for the time period chosen. It reports on :
  Total Medication (non-pt)
  Total PT Medication (by classification)
  Extension Set - Medication Safety
  Total PT Medication Incidents (Extension Activated)
  Medication event relates to
  Order related to
  Was the order
  When/How Medication event identified

What was the Medication event
Medication Route
Medication Type/class
Infusion pump involved
Patient administered the Medication
Was medication administration checking procedure followed
What part/parts of the checking procedure were not followed
Adverse drug reaction
ADRAC notified
Known allergy/sensitivity to medication
Previous known medication allergy/s documented on initial presentation
Adverse Outcome
Corrective Action(s) taken
Medication Reconciliation(Medication Management Plan)
Reconciliation
Additional - Medication Indicators
PT Medication by Facility
TOP 10 PT Medication (Type/Class)
PT Medication (by Service)
Medication Severity - by Outcome (PT)
Medication Serious Outcome (PT)
PT Serious Outcome Ratio
Time Based Analysis

- The "Medication Journey" audit will be considered for later this year to be undertaken by Clinical Pharmacist and QM.

Self Assessment for Survey August 2016

- Medication Safety Self Assessment Audit (CEC) has be undertaken - awaiting results and an action plan will be established once results received.
- A process chart is available for the pathway of Schedule 8 and Schedule 4 drugs for their journey from order to delivery to ward available with local policy support
- A flow chart is available for imprest medications from order to cupboard storage with a supporting local policy
- A flow chart for individual prescriptions order from HPS (pharmacy) to delivering to the patient and ward is available with supporting local policy available for staff to view on "L" drive /Policy/Clinical
- Healthscope Policy available to guide staff 8.75 Medication Management Plan and 8.89 Medication Safety Governance

Completion Due By: 30.10.2015

Responsibility: DON, Drug Committee, Clinical Pharmacist, QM

Organisation Completed: Yes

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

Evidence provided indicated that Medication Management Plans and medication charts are used by medical and nursing staff during clinical handover.

Standard: Clinical Handover
Criterion: Governance and leadership for effective clinical handover
Action: 6.1.3 Tools and guides are periodically reviewed

Recommendation: NSQHSS Survey 1013.6.1.3

Recommendation:

Ensure that tools and guides for clinical handover are periodically reviewed.

Action:

- Clinical Handover compliance is audited as part of the Healthscope Quality KPIs
- A patient Experience Survey associated with Clinical Handover is planned for second half of 2014-2015 audit calendar
- Incidents associated with Clinical Handover is an indicator on RiskMan Incident Data Collection System - in relation to National Standards

September 2015 Self Assessment Progress Reports

- There have been no incidents with Clinical Handover reported in 2014-2015
- The DON surveyed the nursing staff in May 2015 to ascertain acceptable change of shift times to accommodate a 2nd Bedside Clinical Handover within 24 hrs
- The 2nd Clinical Bedside Handover Round was commenced in August 2015 with Night Shift to Morning Shift as well as Morning Shift to Evening Shift.
- The Clinical Handover Tool is stored in L Drive (each clinical staff member has access) and is updated each shift.
- The Clinical Handover Tool is based on ISOBAR tool as recommended in ACSQHC
- Updating the Clinical Handover Tool automatically updates the Hourly Rounding Worksheet
- As well as the Bedside Clinical Handover ,Electronic Patient Information Boards have been installed on each ward -the updates are undertaking directly through webPAS.
- These Electronic Patient Information Boards are installed in discreet areas within each ward available for all health professionals attached to the ward or VMO groups to refer to by a touch screen.
- Clinical Staff have Mandatory E-learning Package for Clinical Handover yearly with a dead line of 31 st December to complete each year. The Staff Educator publishes compliance to this training on a monthly basis. As at 30.8.2015- 50.2 % of applicable staff had undertaken the Clinical Handover E Learning Program.
- Compliance is discussed at the Senior Manager Meetings, the DON has sent out letters to casual nursing staff indicating that if mandatory e- learning is not complied with no further shifts will be made available.
- An Audit is undertaken of the Clinical Handover Process as part of the Quality KPI package . Result of the last Audit 88% compliant to ISOBAR indicators, Previous Audit was at 66% (November 2014)

Self Assessment for Survey August 2016

- Annual Audit of the Clinical Handover again rated well with the uptake of the 2nd bedside handovers per day being reluctantly undertaken by staff. Staff are compliant with the afternoon Bedside handover but the night to day one staff bedside handover still needs staff strong encouragement to comply.
- There were no incidents reported in 2015-2016 related to Clinical Handover Standard
- Healthscope Corporate Office is to release a DVD that includes a detail visual scenario of bedside handover and the pitfalls of bedside handover. This has been produced through the Customer Participation Clinical Cluster and will be shown to staff when available.
- LDPH continues to utilise a purpose design Clinical Handover sheet with a local policy to support the handover practice which is available on L drive for staff to view

- Electronic touch screens have been placed in the wards with outline of patients admitted that can access pathology, expected milestones and risk factors associated with their care. These screens are out of immediate sight to the patient's rooms and visitors.
- Clinical Handover e learning is extended to allied health staff recent compliance is 50% with 4 months available for staff to undertake. A blitz on E learning and Practical competency generally has occurred and this percentage will no doubt be improved at time of the on site survey.
- Allied Health managers have developed a clinical handover policy targeting their personnel and is available on L drive /Policy/allied Health to support the HSP corporate policy.
- Evaluation of Bedside Clinical Handover Aug 2016 Clinical staff indicated 88% agreed to strongly agreed the patient /carer's contribution assists in understanding and planning of care; 90% Agreed to strongly agreed that Checking clinical status, med charts and clinical records during handover reduces omissions, errors and misunderstanding.
- Evaluation of Bedside Clinical Handover by the registrars100% indicated Agreed to very strongly agreed that they were confident that their patients prescribed treatment therapies were checked more thoroughly during bedside handover; they also indicated that feedback from their patients indicated that they felt that their contribution assisted in understanding and planning of care 100% agreed to strongly agreed.

Completion Due By: December 2015

Responsibility: DON +NUMs +AHM

Organisation Completed: Yes

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

Tools and guidelines for clinical handover have been reviewed. Therefore the intent of this recommendation has been met and it is closed.

Standards Rating Summary

Organisation: Lady Davidson Private Hospital
Orgcode: 110112

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: Lady Davidson Private Hospital
Orgcode: 110112

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	1	3	4
Standard 3	33	6	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	19	1	20
Standard 9	14	1	15
Standard 10	18	0	18
Total	**198**	**11**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	1	1	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	2	6	0	8
Standard 10	0	2	0	2
Total	**3**	**44**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	10	1	11
Standard 3	1	0	1
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	6	0	6
Standard 10	2	0	2
Total	**43**	**1**	**44**

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	1	40	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	2	21	0	23	Met
Standard 10	0	20	0	20	Met
Total	**3**	**253**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	11	4	15	Met
Standard 3	34	6	40	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	23	1	24	Met
Standard 9	20	1	21	Met
Standard 10	20	0	20	Met
Total	**241**	**12**	**253**	**Met**