Report of the ACHS EQuIPNational Organisation-Wide Survey

Mount Hospital

Perth, WA

Organisation Code: 52 17 65

Survey Date: 10-12 October 2017

ACHS Accreditation Status: **ACCREDITED**

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

Table of Contents

About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

The action numbering relates to the month and year of survey and the action number. For example, recommendation number OWS 0613. 1.1.1 is a recommendation from an OWS conducted in June 2013 with an action number of 1.1.1.

5 Standards Rating Summary Report

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

Organisation : Mount Hospital
Orgcode : 521765

Survey Report

Survey Overview

Management and staff of Mount Hospital presented well for the National Standards survey undertaken over three days from the 10th to 12th October 2017, demonstrating evidence of their achievements in improving care and services for patients. The hospital is well appointed, clean and aesthetically pleasing.

Mount Hospital is situated near the banks of the Swan River close to Perth's CBD. It is one of 46 Healthscope private health services across Australia, New Zealand, Singapore and Vietnam. Currently, the Mount Hospital has 224 beds providing services primarily for cardiac, breast services, orthopaedics, chemotherapy and endoscopy with a 24-hour priority admission service for patients experiencing cardiac or respiratory problems. There are on call cardiologists providing 24-hour access to the cardiac catheter laboratories which are well supported with diagnostic services including radiology, pathology, MRI and nuclear medicine. Mount Hospital prides itself as being one of the leading private providers of cardiac services in Western Australia with plans to redesign cardiac services into a boutique type cardiac service.

There have been recent changes with key executive positions over the previous twelve months. This has brought a stronger connection between management and the Medical Advisory Committee. These changes have also had an impact across the organisation with clear positivity noted in staff culture and enthusiasm for the future direction of service delivery. Planning for the future role and function of the hospital was well under way at the time of survey and the medical staff indicated their welcome involvement in these processes.

Mount Hospital clearly benefits from the Healthscope Corporate support through the policy and clinical governance framework, shared learnings and involvement in all the Healthscope Cluster Working Groups which continue to focus on requirements of each of the National Standards. Significant work has been undertaken in the last year under the leadership of the new executive team to equip managers and staff with the knowledge and expertise to meet activity and service delivery. It was also noted that the staff generally and the quality team had made great efforts to ensure that all the criteria within the standards were met.

The surveyors were impressed with the high degree of teamwork and the integration of new services for patients. Multidisciplinary team work in both fall and pressure injury prevention has resulted in injury rates below peer average is most impressive. Hand Hygiene rates for all staff groups and VMOs continues to increase and currently is above the Healthscope Benchmark and national average. Management and staff continue to demonstrate commitment to the process of increasing involvement of consumers.

The ability for Mount Hospital to expand is very limited mainly because of the location and enclosure of adjacent buildings. Parking and traffic noise are considered the main issues. Changes to on-site staff parking to a parking facility close by with a shuttle bus service has assisted with parking congestion. There are noise monitors and consumer engagement in strategies to limit local noise issues. Future enhancements to services will include a review of bed occupancy and potential decrease as part of the redesign of the facility to accommodate the planned changes.

Overall, Mount Hospital has performed well and managers and staff are congratulated on their enthusiasm, positive "can do" attitude and achievements demonstrated during this National Standards survey.

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Healthscope clinical and corporate governance systems for patient safety and quality are well established and maintained within Mount Hospital. The Executive Committee, chaired by the General Manager, is the hospital's peak governing committee.

Significant organisational changes have been undertaken recently including the appointment of a new General Manager and recruitment of a number of senior manager positions some of which were still being recruited at the time of survey. Accordingly, a new strategic plan with clear patient safety and quality initiatives was described by the General Manager as being work-in-progress with a clear vision and priorities for the future direction of the hospital.

Clinical, administrative and general Healthscope policies are available for staff on the intranet portal referred to as HINT. Similarly, staff can access both Mount Hospital and Healthcare Infection Control Management Resources (HICMR) policies electronically. All Mount Hospital policies sighted were developed in accordance with Healthscope policy requirements and were current. Compliance with legislation through the Healthscope system of checks and balances is appropriate.

Whilst the organisation structure has clear and concise lines for reporting and communication, the current committee structure is less clear. The survey team suggests the outcome of the next Committee Structure review clearly demonstrates that the Medical Advisory Committee (MAC) and Executive receive and respond to all clinical committees.

The Clinical Review Committee continues to have 'privilege' under the WA State Quality Privilege Legislation Health Services (Quality Improvement) Act 1994 and minutes were not available to the survey team. The role, function and membership of this committee and evidence of decision making and actions for improvement were evident to the survey team through discussions with members of the Medical Advisory Committee and General Manager.

ACHS clinical indicators, Healthscope clinical performance indicators, audit results and morbidity & mortality reviews are reported to the Executive, MAC and Clinical Review Committees. Trended data to determine variances from clinical indicator and audit results with documented action plans for follow up, was evident.

Staff position descriptions clearly identify quality and safety responsibilities and accountabilities. Staff spoken with demonstrated their understanding of quality and risk management.

A comprehensive education program includes orientation and mandatory training for key safety and quality requirements of the organisation. Compliance with annual competency assessment and training is closely monitored by the executive team. Locum and agency staff is provided with an orientation package that includes specific requirements for safety and quality roles and responsibilities.

The integrated risk management system, RiskMan, is well established through a comprehensive collection and classification of risk rated data and analysis by management and staff using the specifically designed extension questions related to the NSQHS Standards. All risks have a clearly identified owner who is responsible for the development of an action plan to address, control and/or mitigate the identified risk. These action plans are included in the Quality Plan and monitored quarterly through the Quality and Risk Committee. In addition, Healthscope 'Shared Learnings' from specific sentinel events are received quarterly for implementation within a defined period of time as determined by the Quality and Risk Committee.

Mount Hospital is required to report quarterly against a range of Key Performance Indicators (KPI) which includes a number of quality and safety indicators resulting from the required Healthscope audit schedule. Action plans to improve specific KPIs are recorded in the quality plan. Staff were able to identify to the survey team the link between the identification of a risk or complaint and the opportunity for a quality improvement initiative.

Clinical practice

A comprehensive range of clinical guidelines are available electronically for staff to access. Since the last survey, there has been a concerted effort to develop and enhance clinical pathways to ensure each is consistent with relevant clinical guidelines and appropriately referenced. More recently, significant work has been undertaken to document patient variances from their pathway. This has provided the appropriate information to plan, manage and evaluate a patient's clinical progression and outcomes of care. The survey team suggests that this body of work could now be further enhanced by undertaking and documenting a clinical record content review to evaluate the appropriateness and effectiveness of patient continuum of care which will, over time, inform opportunities for quality improvement initiatives.

Processes are in place to identify patients at increased risk of harm and span the patient journey from pre-admission, through to preparation for discharge. A range of evidence-based screening and assessment tools are in use. Management plans are developed for patients identified at risk. Performance is monitored through clinical indicators, scheduled audits and the incident monitoring system. Track and trigger observation charts are used to detect early deterioration; rapid response mechanisms are in place and clinical staff are appropriately trained to manage unexpected medical events.

There is an effective, well governed medical records service. Health record policy and procedures are evident. Records are integrated, readily available to clinical staff and appropriately tracked to avoid loss. The design of the clinical record allows for systematic audit of the content.

Several quality improvements projects have been undertaken including the move forward to the development of generic forms for use across all Healthscope services.

Following the recent review by the WA Licensing and Regulator Unit (LARU) with regards to the legibility of staff signatures, several measures have been implemented including staff education and the request for staff to purchase small pocket self-naming stamps. On review by the survey team, it was noted that the staff were either using these stamps or printing their name and designation following each entry. It is suggested that the current documentation audit tool used to assess health record documentation requires adjustment to expand some of the indicators per profession thereby enabling a profession specific review of signatures legibility.

Organisation : Mount Hospital
Orgcode : 521765

Performance and skills management

There is a formal system in place for the receipt and assessment of applications for the specialist medical staff all of whom are visiting medical officers. There is a credentialing clerical support officer who ensures the relevant documentation is sighted and forwarded to the Medical Advisory Committee (MAC). On review of the applicant, the MAC makes recommendations to the General Manager in regard to the suitability for appointment and for the proposed scope of clinical practice. Senior medical and executive staff have attended a training module on credentialing processes. There is a software system that records the documentation for credentialing and creates the personnel records for each VMO. The scope of clinical practice is clearly defined and is tailored to the role and function of the hospital. In the event of a new procedure being introduced to the hospital, the MAC is involved in assessing the procedure and the requirements for defining the scope of practice updating for qualified staff members. The survey team noted the robust process that has recently been undertaken by the hospital in preparation for the introduction of trans-catheter aortic valve implantation (TAVI).

Members of the nursing staff have clinical competency records and competencies workbooks. Courses are approved for skill attainment and retention such as the Peri-operative Cardiac Catheter course. Scope of practice is also defined in the job descriptions of members of the nursing staff. There is an annual audit of compliance with the approved scope of clinical practice.

Supervision of the registrars in Intensive Care and Cardiology service is well structured and effective. Supervision of enrolled nursing staff is also in place.

All members of staff have an annual performance development assessment. There are three tools utilised for the appraisal depending on the role the staff member undertakes. The system is linked to ongoing education and development of staff members. Feedback from the workforce indicates that over 80 per cent feel that the assessments were fairly evaluated.

Education is provided to staff members via an eLearning tool that encompasses the role in safety and quality for staff members. Staff surveys have indicated that almost all staff members were familiar with their quality and safety roles.

Incident and complaints management

A range of Healthscope policies guides managers and staff in the use of RiskMan for recording, investigating and managing clinical, administrative and work health and safety incidents, near misses and complaints. RiskMan entries are automatically delivered to the Executive team. All incidents and near misses are risk rated. Incidents involving significant adverse patient outcomes (SAC1) are reported to WA Department of Health within 7 days and Healthscope within 24 hours. All SAC 1 incidents are investigated by the Clinical Review Committee. Sentinel events are reported to the Quality & Risk Committee and the Executive. The results of all critical system reviews are submitted to Healthscope and incorporated into the Healthscope Shared Learnings' process.

Complaints management and investigation is undertaken in accordance with Healthscope policy 1.08 'Complaints Management'. A patient liaison officer actively follows up all complaints within the required Healthscope criteria under the supervision of the Director of Nursing. All complaints are entered into RiskMan, managed, reported as a KPI and trended.

The Healthscope policy 2.30 is used to direct the open disclosure process with patients, family and carers. Generally, the treating VMO and a member of the executive would speak with the patient and/or family in the event of an incident. At the time of survey 98% of relevant staff had completed open disclosure awareness training.

Patient rights and engagement

Healthscope has a Charter of Patients' Rights which is clearly displayed at all entrances to Mount Hospital. Information on patients' rights is provided to every patient on admission in a brochure. This brochure has been consumer endorsed. The admission pack documents collated by the relevant clerical staff includes a variety of consumer information that cover aspect of patients' rights and engagement. In addition, information is available to patients on the hospital web site, on the TV video network. An interpreter service is available but seldom used as over 90% of admissions are from an English-speaking background. A recent audit undertaken of consumers indicated that 92.3% of patients understood their rights to support informed decision making during their admission.

Patients are required to indicate whether they have an Advanced Health Care Directives (AHCD) on admission which is recorded in the admission history as either a "yes" or "no". When received, the process is for the AHCD to be filed in the patient medical history as per policy. At the time of survey, the survey team was unable to find a patient's medical record with an AHCD filed particularly from health records that were reviewed in the medical wards where it would be of value to ensure this process was being monitored.

Not for resuscitation (NFR) orders were developed in consultation with the patient and filed according to local guidelines.

The patient's medical record is noted to be available at the point of care with relevant processes to support the retrieval of offsite stored medical records within a timely manner. Recent audits indicate that 100% of retrieval of medical records were retrieved within the requested timeframe, this audit included the retrieval of medical records within 120 minutes as required for the retrieval of medical records for urgent admissions.

Systems are in place to restrict access to medical records with the main Medical Records Department; access restricted to only those requiring access. This includes relevant clerical staff and the After-Hours Managers during out-of-office hours for urgent admissions. Policies and processes for the management of staff adherence to patient confidentiality and staff code of conduct are presented to all staff at orientation. Medical records that are stored outside of the main records department are kept in staff only locations behind the clerical area or secured behind locked departments.

Patient feedback systems have been developed and well established throughout the hospital. Several brochures have been developed including the "Mount Hospital Your Feedback" Brochure and the Healthscope "Your Impression of the Mount Hospital". This information is collated and provided to the hospital Consumer Advisory Committee (CAC) as a regular agenda item.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Mount Hospital's Partnering with Consumer policy encompasses processes to assist with consumer participation. There are four appointed consumer consultants with one being a member of the Quality and Risk Governance Committee. There is a current plan to consider opportunities to expand the number of active consumer consultants. Opportunities for consumer feedback is through the reporting process of inter-hospital committees either presenting report to the Quality and Risk Governance Committee or tabled at the Consumer Advisory Committee which meets quarterly. Evidence presented indicated that audit report results, clinical indicators and other operational issues were regular agenda items thereby ensuring consumer feedback and input into the clinical and organisational governance, patient safety and organisational quality improvement initiatives.

Mount Hospital provides orientation and ongoing training to consumers as well as a well-developed role description to support the consumer with the fulfilment of their partnership role. Consumers are involved in the orientation of new staff.

The Consumer Advisory Committee (CAC) is provided reports with opportunities to feedback improvements in patient brochures. Each brochure presented to the committee is assessed against a range of set criteria and several of the consumer suggestions have been incorporated into the final document. Most of the brochures that were reviewed on each area visited by the team noted a small stamp (tick) on the back to indicate consumer approval.

Consumer partnership in designing care

Several of the CAC members have been invited to provide feedback into aspects of designing/ redesigning care. New programs where they have been involved include the Transcatheter Aortic Valve Implementation program and the new Volunteers program. Future discussion will be focusing on the review of new services that will shortly be underway for cardiac services, planning for the hybrid theatre and the patient journey project which will be facilitated by one of the committee members.

Patient Centred Care is well established with staff undertaking in-service with a compliance rate of 98%. There is a dedicated session provided for staff at orientation. One area that was particularly noteworthy is the inclusion of patient involvement on the admission process and in the development of their care pathway. Patients continue to be involved in the ongoing management of their care. This was noted to be the case in many of the pathways available and reviewed by the survey team.

Consumer partnership in service measurement and evaluation

Opportunities are available for consumers to provide feedback on service delivery through several methods. A feedback brochure is included as part of the admission pack and pamphlets on feedback, compliments and complaints are clearly displayed in all public areas. Patient feedback data is reviewed by the Consumer Consultants as part of the agenda item. One initiative that has been progressed has been through patient feedback on noise, with suggestions to implement strategies on noise reduction.

Safety and quality information is produced to the Consumer Advisory Committee, on display boards in wards and departments and provided on the MyHealthscope website.

Organisation : Mount Hospital
Orgcode : 521765

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Effective governance and management systems are well established for Infection Prevention and Control (IP&C) through a contracted service with Healthcare Infection Control Management Resources (HICMR). The current and previous Infection Control Plans sighted are comprehensive and reflect the service provision for Mount Hospital.

There is an extensive range of relevant HICMR, Healthscope and Mount Hospital policies and procedures which are evidence–based and/or best practice that are compliant with The Australian Guidelines for Infection Control in Hospitals (2003). A broad range of HICMR evidence-based risk assessment tools are used to assess compliance with infection prevention and control standards, guidelines and legislation. Each tool has an associated action plan to address low compliance. The infection control program and compliance monitoring are overseen by the multidisciplinary Infection Control Committee (ICC). The ICC is chaired by an Infectious Diseases Physician, meets quarterly and reports to the Executive Committee through the Quality and Risk Committee. The survey team suggests that there is an identified need to ensure the MAC membership has the opportunity to receive and respond to minutes of the ICC. (Refer also to comments in Standard 1).

A qualified Infection Control Coordinator with support from the HICMR Consultant ensures that the unit based link nurse program proactively enhances IP&C practice throughout Mount Hospital. Managers and staff also benefit from receiving shared learning opportunities through Healthscope IPC Cluster as well as receiving HICMR newsletters.

Surveillance data for ACHS IP&C Clinical Indicator (CI) and Healthscope IP&C KPIs are collected, trended, submitted and benchmarked. In addition, WA Department of Health HIP&C surveillance data is required to be reported. Results of CI and KPI and surveillance data are closely monitored and action taken, including critical systems review and staff education, to address poor and non-compliant performance.

Infection prevention and control strategies

A range of IP&C activities are undertaken. Recent hand hygiene audit results indicate improvement with the most recent hospital-wide result being 87.9% which is above the Healthscope benchmark and national average. Nevertheless, the results indicate opportunities for continual improvement for all occupational groups.

Whilst a comprehensive workforce immunisation program is in place and all new employees are required to show evidence of compliance with Healthscope Policy 4.26, there has been poor compliance demonstrated by existing staff resulting in a current hospital wide compliance of 52%. Similarly, recent flu vaccination rates of 25% which is well below the state-wide rate for health organisations of 45%. The survey team was informed that whilst the four volunteers had received flu vaccination there is no vaccination history held for them currently. Accordingly, it is suggested that the current action plan be strengthened to include more specific strategies to address non-compliance of all staff and volunteers with the Healthscope Policy.

Staff compliance with the use of personal protective equipment (PPE), sharps and clinical waste management is monitored closely and corrective action taken to improve compliance. This involves correct and appropriate use of face masks, eye protection and gloves as well as compliance with hospital policy to meet the Australian College of Perioperative Nurses (ACORN) standards in operating theatres (OT) and cardiac catheter labs (CCL) in relation to theatre attire especially when entering and leaving each area. There is also an identified need to continue to reduce the injury and exposure rate from both parenteral and non-parenteral exposures sustained by staff.

The safe use and management of invasive devices is closely monitored and overseen by the ICC. Whilst specialty units such as CSSD, OT and CCL have separate lists of invasive devices held in each department that are able to be tracked back to a patient, there does not appear to be a process in place to track sterile invasive devices such as indwelling catheters and intravenous cannulas ordered through the store department. It is suggested that this could be rectified by recording batch numbers of relevant invasive devices received into the stores area for use across the hospital. A product evaluation form is required to be completed for approval to introduce a new invasive device.

Education in the use and management of invasive devices dovetails into aseptic technique education and competency assessment. The survey team were impressed with the initiative to produce two videos designed to demonstrate for the correct use of aseptic technique for wound dressing and management of IV sites which has enabled the requirement to have 100% of relevant staff to be trained and assessed as competent in aseptic technique.

Managing patients with infections or colonisations

An active surveillance program is in place for early detection and management of infections and patient colonisations. Recently this has been enhanced by the implementation of the RLSolutions database for earlier notification of patients with a positive pathology.

Patient self-declaration in the comprehensive pre-admission history provides the access team to determine the need for either standard or transmission based precautions. The use of a WebPAS alert system ensures managers and staff are well informed of clinical and cleaning requirements for patients.

Whilst audits of staff knowledge and understanding of standard and transmission based precautions indicate 98% compliance it is suggested that more frequent ‘just in time’ observational audits be undertaken and documented when transmission based precautions are in place to complement the current annual audit of staff knowledge and understanding. Similar observational audit of staff compliance with standard based precautions is encouraged.

Antimicrobial stewardship

The hospital commissioned an Antimicrobial Stewardship (AMS) program in 2013. There is an Antimicrobial Stewardship Committee that is the mainstay of the governance system that includes a medical specialist in microbiology and in infectious diseases, the hospital pharmacist, and the infection control coordinator. The links from this group to the Drug and Pharmacy Committee and the Infection Control Committee are in place and utilised. There are restrictions on the prescribing of a standard range of antimicrobial agents, and compliance with this is checked. Therapeutic guidelines are readily available to staff members. Benchmarking opportunities in regard to drug usage is undertaken and the results are favourable. Point prevalence surveys are undertaken every six months along with National Antimicrobial Prescribing Survey (NAPS) reporting. The committee has been encouraged by the improved outcomes achieved in the appropriate use of surgical prophylaxis and its timely cessation.

The survey team noted that the medical officer on the committee did present an annual report to the Medical Advisory Committee. Minutes of the AMS committee quarterly meetings are forwarded to the Infection Control Committee. It is suggested that the minutes of the AMS committee are also forwarded to the MAC every quarter for their consideration. The survey team noted that the AMS committee members were refining the database for their use in recording AMS issues. The support and assistance of the hospital in the ongoing development of the database would be most helpful.

Cleaning, disinfection and sterilisation

HICMR policies and procedures for environmental services based on risk management principles are available electronically for staff in cleaning, waste management, laundry and linen transportation, cleaning and storage, air handling system, cooling tower management and legionella detection in water systems, pest control and preventive maintenance and quality testing of steam generators, sterilisers and washer disinfection maintenance. Annual risk assessment audit conducted by HICMR result in a compliance report and action plan to address areas of non-compliance.

Environmental cleaning schedules are in place and undertaken on a regular basis with greater than 90% compliance evident in 2017. Cleaning schedules were evident in all clinical utilities and storage areas. Surveyors observed the appropriate use of neutral detergent wipes for cleaning patient related medical equipment in all areas of the hospital. The hospital presents as clean and relatively uncluttered.

The survey team noted that Formalin is decanted by staff into specimen buckets in the specimen room located within the operating theatre suite. Whilst there is a fixed fume cabinet with a hepa filter, a spill kit and clear directions for staff to follow including the need to gown, mask and wear gloves for the process of decanting, the survey team identify this practice as not being best practice and suggest the ongoing practice be reviewed accordingly. Refer also to comments Standard 15 summary for Action 15.12.1.

The purpose built central sterile services department (CSSD) is designed to meet the requirements of AS/NZS 4187:2104. Unfortunately, the construction of this building resulted in the loss of physical access for staff between the OT and CSSD without them having to change all theatre attire every time there is a need to enter either area to ensure compliance with both ACORN Standards and hospital policy. The only internal access created in the new building is via two separate equipment hoists designated ‘clean’ and ‘dirty’. Clearly this issue results in both a loss of staff time and excessive use of theatre attire. The survey team suggests that opportunities to create appropriate internal physical access between CSSD and OT be explored and considered.

A comprehensive gap analysis for the cleaning, disinfection and sterilisation of reusable instruments and devices has been undertaken to assess the hospital’s compliance with AS\NZS 4187:2014 and used to complete a detailed implementation plan to address all identified gaps in the next two years.

A manual Meditrax tracking system is used to identify and track all scopes, transoesophageal echocardiography (TOEs), and instruments/ and trays back to the individual patient. This system and the integrity of the process for cleaning, disinfection and sterilisation is closely monitored on a daily basis and is well supported by the annual HICMR risk assessment audits to ensure any breach is detected before potential or actual harm occurs to a patient.

Overcrowding and reduced air changes in the central storage and preparation area of the operating theatre suite used for instrument set ups was identified in a recommendation in the 2017 WA Health Licensing and Accreditation Regulatory Unit (LARU) report. This recommendation appears to have been addressed by a change in practice to ensure only one set up is done at a time to avoid interference with required air changes. Other recommendations in the LARU report within theatre and CSSD related to compliance with required air changes have all been corrected and or mitigated and continue to be monitored.

During survey, the cardio thoracic theatre (OT/10) anaesthetic bay was observed to be blocked with excess cardiac equipment removed from the theatre whilst it was being utilised for a ‘long’ plastics case requiring laminar flow. This anaesthetic bay is both the entry and exit point for the transfer of patients. Consequently, it is suggested that a process be established to ensure anaesthetic bays are not used to store surplus theatre equipment especially during a scheduled operation to ensure patient safety is not compromised during transfer from theatre.

Communicating with patients and carers

The “MyHealthscope” website provides public access to Mount Hospital acquired infections and hand hygiene compliance rates of staff and doctors. Appropriate brochures are available for patients and families on the management and reduction of healthcare associated infections. Appropriate signage in lifts, corridors and public places prompts visitors to wash their hands and use appropriate cough etiquette. Patient and consumer feedback on the usefulness of provided information is sought and used for improvement.

Organisation : Mount Hospital
Orgcode : 521765

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

Evidence sighted that 98% of relevant staff have been trained in aseptic technique and 97% have undertaken a competency assessment. Accordingly, this transitional Action is fully met at the SM level.

Organisation : Mount Hospital
Orgcode : 521765

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

Organisation : Mount Hospital
Orgcode : 521765

Action 3.16.1 Core

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

Surveyor Comment:

A Gap Analysis has been undertaken for compliance with AS\NZS 4187:2014 which has identified a number of gaps to be addressed to demonstrate compliance. A detailed Implementation Plan is in place to address all identified gaps in cleaning, disinfection and sterilisation of reusable instruments and devices.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

There is a Drug and Pharmacy Committee as part of the governance structure of medication management. The objectives of the committee are appropriate for the role of the committee and the membership includes a pharmacist, nursing staff and a medical officer. The survey team noted that the medical officer had not been in attendance at recent meetings. Accordingly, it is suggested that the availability and involvement of a medical officer for this committee be reviewed. The committee reports to the Quality and Safety Committee on a quarterly basis. Prescribing guidelines are issues particularly in regard to antibiotic medications.

Staff education is in place and one of the primary mechanisms for education is the undertaking by the clinical staff of the Med Safe Internet learning program. The survey team noted that the committee members are aware of the recent changes to the WA Health regulations regarding drug and medication management.

Medication authorities are linked to staff members' scope of practice and the pharmacist has access to nursing staff database and medical staff signatures. Medication incidents are recorded in RiskMan and generated trended reports are reviewed by the committee. There is no pattern to current medication events and there has been no event in recent times that required a root cause analysis. A quality improvement activity initiated by the pharmacist has been the application of bar coding of all imprest stock at ward level. The utilisation of bar coding techniques is encouraged. Other quality improvements include standardised medication orders, updated medication policies and smart infusion pump technology.

Documentation of patient information

A medication history is gained and recorded starting with the pre-admission patient forms, the pre-admission clinic, and the verification undertaken by the ward pharmacist. When necessary the community pharmacist is contacted as is the patient's General Practitioner. This information is recorded in the patient's medical record. Patient allergies and adverse reactions are recorded on the alert sheet and in the patient admission system. Red patient ID bands are also applied. The pharmacist ensures any drug reactions are reported to the Therapeutic Goods Administration (TGA). Medication reconciliation is undertaken on transfer of care and the compliance with this policy is audited and trended with good outcomes being achieved.

Medication management processes

Information and decision-making tools are available to staff members. MIMS is online in the clinical areas and the pharmacy service has provided a "Pharmacy Fact File" in every ward. The Pharmacy fact file is noted for its usefulness and popularity amongst staff members. In the ward areas and the pharmacy, secure storage is provided for all medications including those requiring temperature controlled environment. The survey team noted that in the operating suite there is only one secure Schedule 8 (S8) cupboard. In accordance with best practice it is suggested that each operating room be provided with a secure S8 drug cupboard. Audits of the drug storage and imprest systems are carried out on a regular basis.

The hospital pharmacist has oversight of the disposal of unused, unwanted and expired medications. In regard to high risk medications the **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy and **h**eparin (PINCH) system is applied in the hospital. Audits have revealed a good level of compliance. There are specific policies for IV insulin, IV heparin and the usage of smart infusion pumps. Tall man lettering is in use, and the national recommended labels for injectable medicines are available in all clinical areas. It is suggested that the hospital expedite the availability of a software package for the prescribing and administration of medications in the chemotherapy unit.

Continuity of medication management

On admission, a patient medication history is obtained and verified. This is recorded in the medical record system. During the inpatient stay. the medication lists are updated and a medication plan is provided for inpatients. A medication Medi-Pal profile is created and at the time of discharge a list of medications is available. The current medication of inpatients is reviewed at time of handover as well as at time of discharge or transfer.

Communicating with patients and carers

Patients are provided with medication information by the hospital pharmacist. Medication management plans are constructed for patients staying longer than two nights and patients on four or more medications. Patient surveys have revealed a good level of satisfaction with the information being provided about their medications.

Organisation : Mount Hospital
Orgcode : 521765

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Mount Hospital applies the Healthscope policy “Patient Identification Bands 2.08” (November 2016) which requires that labels have four patient identifiers. The approved identifiers are Unit Medical Record Number, surname and given name, date of birth and gender. The policy requires that the band is applied “on arrival to the admitting ward” and not at the time of seeing the admission clerk. The survey team noted this practice while on visits to the chemotherapy ward and other clinical areas, for example patients having elective surgery. In the event of any delay in the patient being received in any unit or ward in the hospital, for example through the patient becoming ill or an operational reason, there is potential for a risk around patient identification. After raising this issue with management during the survey, it was decided to mitigate any risk by having the patient identification band applied in reception. It is suggested that the hospital review this potential risk for all admissions which may include a review of the policy.

In cases where patients have the same or similar names, an alert sticker is placed on the medical record, bed card, nursing handover and patient lists.

There is a good practice of auditing the use of identification bands, the use of time out before medical procedures and the use of two identification bands for all patients going to the operating suite. This practice of using two bands is entered on the risk register, as there is the potential for mismatching procedures.

Results of the monitoring of patient identification systems are reviewed regularly by the General Manager, Theatre Manager, Nurse Unit Managers, the Medical Advisory Committee and any incidents or near misses are logged in RiskMan.

In the last couple of years there has been action to increase compliance in the use of patient identification bands due to some errors entered by new clerical staff. An extensive education process around the clerical processes has occurred and there is now excellent compliance.

Processes to transfer care

Patients that transfer from one Mount Hospital unit or ward to another retain the identification band. If the band needs to be removed pre-operatively, an identical band is attached to another limb as soon as possible by the same person. If the band is removed by a VMO, a nurse is informed and a replacement band is obtained and attached to the patient. Checking of patient identification occurs each time care is transferred, such as from shift to shift and between unit to unit patient transfer.

Processes to match patients and their care

Mount Hospital applies the Healthscope policy “Correct Patient, Correct Procedure Correct Site 2.15” (March 2015) which outlines the requirements for the patient verification process, marking the procedure site, procedure suite reception checks, sign-in checks which includes the patient, anaesthetic time out, and team time out. In the event that surgery occurs on the incorrect patient, incorrect procedure or incorrect site, the policy outlines actions to be carried out.

Surgical safety checklists are used routinely.

Regular auditing occurs of patient identification bands and team time out. Overall, there is very good compliance with scores over 96% in the audits performed in 2017. Audit results indicate opportunities for improvement with participation by Surgeons and Anaesthetists, with compliance scores averaging in the mid-80%.

Action plans, post-audit are developed and were sighted by the survey team. Actions include the provision of immediate feedback, referring results to the Medical Advisory Committee and/or discussion at team meetings.

A recommendation in the recent 2017 WA DOH LARU report has resulted in a change in process for the collection of pathology specimens from theatre by pathology staff. Given this very recent change in process the survey team suggests that the new process be regularly monitored and evaluated to ensure correct handover of specimens includes correct patient, correct specimen and correct pathology practice.

The surveyors noted that no patient identification checking occurs when delivering meals and should a patient move rooms (as was observed by surveyors), there is potential for error. It is therefore suggested that Mount Hospital review the process for food delivery to patients at the bedside to ensure the correct meal is provided to the correct patient.

Organisation : Mount Hospital
Orgcode : 521765

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Mount Hospital applies the Healthscope policy for clinical handover. The hospital uses the ISOBAR (identify–situation–observations–background–agreed plan–read back) format for handover. The policy, which includes departmental and intra-unit handovers, outlines the principles to be followed. These include ensuring privacy, archiving handover sheets for six months and recording any adverse events due to absent or incomplete handovers in RiskMan.

Any risks recorded are discussed at the monthly Quality and Risk Management meetings. Should a risk be identified an action plan is then developed. Learned experiences from other Healthscope hospitals are shared at these meetings. An example of an action plan developed after an audit in June 2017 was to roll out communication skills training for staff and to provide for staff rotation between surgical specialty wards and operating theatres to help staff understand the type of information needed from different perspectives.

To maximise the effectiveness of clinical handovers, a range of actions are undertaken, including the attendance of Nurse Unit Managers at handovers, observational audits, the use of whiteboards in staff areas and also in patient rooms.

Clinical handover processes

Staff are provided with education regarding clinical handover including a video regarding the use of ISOBAR. Patient files include a laminated sheet outlining ISOBAR as an aide memoire.

No significant issues regarding clinical handover have been noted in recent times, but should any issues arise, they are discussed at Nurse Unit Manager Meetings, monthly unit specific meetings and at monthly ward meetings, where there is a standing item for clinical handover matters.

A quality activity undertaken on wards in May 2017 was for the outgoing shift coordinator to allocate patients to staff for the incoming shift. This activity was identified due to some wasted time for incoming staff while allocations were made, thus reducing time to care for patients. Following the introduction of this approach, it is applied 100% of the time and anecdotal feedback is that it is a better system.

Patient feedback is obtained through surveys and from general feedback forms. Results provided to the survey team showed that patients like being involved in their bedside handover.

The survey team was able to observe clinical handovers. Bedside handovers that were observed were good; however, the group shift to shift handover observed could be improved to ensure that full patient identifiers are used consistently. This was discussed with Nurse Unit Managers at the time, who advised they would monitor the compliance. It is suggested that all ward/ unit handovers are monitored and audited to ensure appropriate identification of all patients occurs.

Patient and carer involvement in clinical handover

Mount Hospital uses a “clinical pathway” form, which is the patient care plan. Patients are included in the development of these and sign them. Results of audits were sighted and, while there is good compliance, ongoing staff education and discussion at ward meetings is occurring to further improve compliance.

Organisation : Mount Hospital
Orgcode : 521765

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Mount Hospital has a Blood Transfusion Committee which is chaired by the Consultant Cardiac Anaesthetist and includes the Consultant Haematologist, Transfusion Special Nurse and representatives from both Pathology Services (Western Diagnostic and Clinipath Pathology). This committee meets quarterly. The committee reports to the Medical Advisory Committee (MAC). A range of local policies procedures, guidelines and prescribing protocols were evident and consistent with national based references and resources involving the administration of blood and blood products. Staff access is via the hospital intranet site. Current practice suggests there is an opportunity for improving clinical prescribing practice. Accordingly, the survey team would suggest that following a review of current practice for non-critical patients, consideration be given according to the National Blood Authority (NBA) Australia requirements to move the focus to the patient to ensure that following the transfusion of a single unit a clinical assessment is undertaken prior to further treatment.

Audits are completed against current protocols to monitor issues such as completeness of documentation, mandatory BloodSafe training and blood refrigerator monitoring.

Haemovigilance processes are evident and include the monitoring of local blood related incidents which are monitored by the Blood Transfusion Committee to identify actions or recommendations. The Quality and Risk Committee also reviews blood related incidents.

Given that blood transfusions occur across most of the services provided by Mount Hospital it would be warranted that an organisational mapping process be undertaken to identify the location, procedures, types and amounts of blood products used to gauge the cycle of activities, review current practices, assess risk and identify opportunities for improvements.

Quality improvement activities include the introduction of a Healthscope Blood Transfusion and Documentation form (2016) which provides the clinician with prompts to enter the patient's blood transfusion history and the recruitment of a new Blood Transfusion Nurse position. The Consent for Medical and/or Surgical Treatment form which includes a tick box to indicate patient consent to blood transfusion if required, continues to be used. This is checked on entry to theatre particularly with those patients who have a procedure that typically requires a blood transfusion. Additional information is provided to patients in the Mount Hospital Blood Transfusion brochure. The result has been an increased compliance for obtaining blood consent and the Blood Transfusion Nurse has provided stability in the management of blood transfusion audits, incident monitoring as well as the monitoring of blood related equipment.

Documenting patient information

Patient medical records are reviewed and audited for compliance against blood transfusion policy and process. The introduction of the new Healthscope Blood Prescription and Documentation form includes a prompt for entry of the patient's history and consent. Auditing of this process monitors medical staff to be completing the blood transfusion as part of their medical history prior to blood transfusion.

Staff are informed of the requirements for documentation of blood processes and this is included as part of their training. Staff are required to undertake BloodSafe training with compliance currently at 92%. This training is mandatory for all clinical staff prior to assisting in any blood transfusion.

Organisation : Mount Hospital
Orgcode : 521765

Managing blood and blood products safety

There is one blood fridge on site that is stocked by both pathology services (Western Diagnostic Pathology and Clinipath Pathology). Mount Hospital managers are responsible for the monitoring of the fridge's temperature and the Transfusion Nurse oversees the maintenance of the fridge and the keeping of records. Cold chain breaches are manually checked daily with an alarm system to alert staff of any irregularities. The fridge is cleaned on a monthly based and the care maintenance and performance for temperature and spatial levels are completed against the requirements for the for medical refrigeration equipment.

Both laboratories are NATA (National Association of Testing Authorities) accredited. Each service is responsible for the delivery of blood to the blood fridge. Both pathology practices monitor the blood usage independently and provide separate reports to the Blood Transfusion Committee. Blood wastage is monitored by both pathology practices and the usage is monitored by the hospital. Currently, 100% of all requests for blood transfusions are used.

Communicating with patients and carers

Mount Hospital has developed a Blood Transfusions brochure which covers issues to inform patients on the need for a blood transfusion, associated risks and alternatives to blood transfusion.

The process for obtaining consent for blood transfusion has been changed with the introduction of the Healthscope Blood Prescription and Documentation form used as well as the Consent for Medical and/or Surgical Treatment form which has increased the compliance rate for patient consent.

Organisation : Mount Hospital
Orgcode : 521765

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

Organisation : Mount Hospital
Orgcode : 521765

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The Healthscope policy 8.05 implemented in Mount Hospital complies with the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. A multidisciplinary Pressure Injury Prevention (PIP) Committee oversees compliance with injury prevention and management practice. Two representatives from this committee participate in the Healthscope Cluster Group for the Pressure Injury Prevention.

The PIP Committee reports to the Quality and Risk Committee and the Executive all results of audits, reported incidents and both hospital and community acquired pressure injuries. Quarterly Healthscope KPI for hospital acquired pressure injury (stage 2 and greater) is required to be reported.

Preventing pressure injuries

The Braden Risk Assessment tool is used to identify patient risk and implement the required prevention plan. Strategies for the prevention, treatment and management of pressure injuries include the use of high density mattresses, heel protectors, Roho cushions, and the use of a specific protein supplement Arginade for identified malnourished at-risk patients. A pictorial inventory of equipment has been developed by the PIP Committee to enhance staff knowledge and selection of appropriate equipment.

Each clinical area has an appointed PIP champion who attend a monthly meeting to improve their knowledge and understanding of pressure injury and prevention and share this valuable information with their colleagues in their clinical areas, promote best practice and assist in auditing compliance with policy.

A regular audit is undertaken to assess the number of patients screened and assessed on admission and how many of these who are identified as being at risk of pressure injury. It is suggested that this information be used regularly to determine the number of identified at risk patients who still develop a pressure injury to enable a critical review to be undertaken to determine all causative factors.

Managing pressure injuries

Prevention plans for identified patients at risk of pressure injury are printed on the reverse side of the Braden Risk Assessment. Effectiveness and appropriateness of pressure injury prevention plans are reviewed during clinical bedside handover each day.

Incidents of both community acquired and hospital acquired pressure injuries are required to be recorded in RiskMan, clinically reviewed to determine causative factors and actions taken as required.

Whilst significant work has been undertaken to reduce the number of hospital acquired pressure injuries there remains an ongoing need for continual improvement.

More recently a purple pressure injury sticker has been introduced to identify if the injury was present on admission or hospital acquired, the date, site, and determined stage of the injury plus signature of reporting person. It is suggested that this sticker would be enhanced if a second signature from the NUM or Wound Manager be required to verify the site and stage of the pressure injury. The survey team discussed the colour currently used for this sticker conflicts with the colour purple being used to denote chemotherapy.

Mount Hospital is fortunate to have the resources of a proactive expert wound consultant who supports the committee and staff. An evidenced based wound management system is well established in line with National Guidelines for Wound Management.

Communicating with patients and carers

Patient and carer involvement in the prevention and management of pressure injury and wound management was clearly evident to the survey team. Patients are provided with the Clinical Excellence Commission (CEC) Pressure Injury Prevention two-sided sheet which clearly identifies simple steps to avoid injury. Plans are in place to further enhance patient education through the use of a video that can be played on the hospital TV channel.

Organisation : Mount Hospital
Orgcode : 521765

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

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

Surveyor Summary

Establishing recognition and response systems

Mount Hospital has a Medical Emergency and Resuscitation Committee that reports to the Medical Advisory Committee (MAC). This committee meets quarterly for oversight of all governance aspects associated with recognising and responding to clinical deterioration. Policies and procedures are evident for areas such as the measurement and documentation of observations, escalation of care, communication, training and the management of equipment. The appointment of a Resuscitation Coordinator (18 hours per week) has supported the management of training, audit and improvement for the management of patient deterioration across the organisation.

Data is collected for review of recognition and response systems for deterioration by the Medical Emergency and Resuscitation Committee. Audits include the monitoring of documentation, incidents of deterioration and the emergency trolleys located throughout the facilities. These have been standardised. Identified actions for improvements to the effectiveness of these systems are reviewed by the committee and/or registered as quality improvement activities.

Deaths from cardiac arrests for patients without an agreed treatment limiting order are monitored post mortality with the aim to assist with the identification of failures to the system. However, the process of review of treatment limiting orders is not undertaken post Medical Emergency Team (MET) calls. To support the effective and efficient use of the response process and resources for a MET call, it would be beneficial as part of this auditing process to consider audits post all MET calls to ensure that patients with treatment limiting orders have been recognised prior to the staff calling the emergency, particularly if adverse issues are evident post event.

Recognising clinical deterioration and escalating care

Mount Hospital uses a general observation chart the Adult Deterioration Detecting Chart (ADDC) which includes a score. This observation chart complies with the required human factor principles to include the capacity for clinicians to record vital signs and the level of consciousness graphically over a prescribed time. The chart includes thresholds for each of these parameters to include abnormality and other factors to trigger escalation with notation of actions required according to the score. The survey team noted that the required observations are linked with the relevant clinical pathway for example the clinical pathway for Respiratory/General Medicine requires observations to be taken and recorded QID following a base-line measure. However, these observations can be increased accordingly.

There are several other charts in use that have been designed incorporating human factor principles include the Recovery Observation Chart, the Patient Control Analgesia Chart, Ketamine Infusion Chart and the Patient Controlled Epidural Chart.

Clinical incidents are registered into RiskMan incident database and both these and the audit of the Observation Charts are collated by the Resuscitation Coordinator for review by the Resuscitation Committee, the Quality and Risk Committee and the Nurse Unit Managers' committee.

Organisation : Mount Hospital
Orgcode : 521765

Responding to clinical deterioration

Clinical staff are required to undertake Basic Life Support (BLS) training with the current compliance level of 96%. This training is provided in-house by the Resuscitation Coordinator who also provides Advanced Life Saving (ALS) training to all nurses who form part of the response teams. All Cardiac and ICU Medical staff are ALS trained. There are two response teams one for medical emergencies (MET) that is in response to deterioration and the Resuscitation Team for cardiac arrest. Both teams are supported from a nominated medical personnel from either the Coronary Care Unit or ICU.

Evaluation of the response team is via audit. There is a form to complete post event or from data from clinical incident review. Issue of review include activation rates, location timeliness of response, outcomes and event evaluation.

Communication with patient and carers

Published information on Advance Health Care Directives (AHCD) is available for consumers. Staff are trained to ask the patient if they have signed an AHCD and this is ticked on the patient admission form. If there is an AHDC the process is to file document in the front of the patients' medical record.

Patients are provided with information on mechanisms to escalate care. Episode of patient/carer escalation are few and monitored by the Resuscitation Coordinator.

Organisation : Mount Hospital
Orgcode : 521765

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

Action 9.6.1 Core

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

Surveyor Comment:

The surveyors noted that all the requirements to meet this Action are in place with the current compliance rate of 96%.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Mount Hospital has a Falls Management Committee and a Falls Management Champion, who is also a member of the Healthscope Falls Cluster which provides for the sharing and dissemination of information and strategies across the broader organisation.

Mount Hospital are currently reviewing the policy on falls prevention and management with a view to include the provision of a visual stimulant to staff to prompt when a patient requires assistance or an aid to prevent falling. Coloured cards, applying a traffic light system, outside a patient's room serves as the prompt and is being trialed currently. At next survey, the surveyors will be interested to see how this initiative has developed.

An example of how staff are alerted to changes in the Falls Risk Assessment and Management Tool was provided to the survey team; where changes had been made, a template had highlighted areas to indicate the change; for example, where there are two or more episodes of nocturia, it indicated high risk. Cognitive assessments are included as part of the tool.

Falls and near miss incidents are recorded in RiskMan and discussed at Nurse Unit Managers' meetings, the Quality and Risk meeting and the Executive meeting.

The surveyors observed strong clinical leadership in this area.

Best practice guidelines are available for staff on the shared electronic drive, including the Australian Commission on Safety and Quality in Health Care documentation "Preventing Falls and Harm from Falls in Older People". A best practice risk assessment tool is in use and regular auditing occurs with good compliance.

Screening and assessing risks of falls and harm from falling

All patients are screened for falls on admission and if indicated, a falls prevention and management plan tool is completed.

Action plans are developed following any incident and patient care plans are modified and another risk assessment completed in the event of a fall or near miss. A significant amount of analysis data and trends is undertaken. Trend reports sighted by the survey team identified a higher rate of falls during nursing handover times. The highest rates occur in cardiothoracic wards. Action plans have been developed and have included education for staff, the increased use of non-slip socks for patients, improved lighting and signage.

Audit results reviewed by the survey team showed a high compliance in the completion of falls risk assessment tool.

Preventing falls and harm from falling

A blanket referral to the allied health team occurs when a falls risk is identified and assessments by occupational therapists, physiotherapists and/or pharmacists are undertaken as appropriate. This allied health group are members of the Falls Risk Committee.

Occupational Therapists have input into the nursing discharge summaries on the rehabilitation ward and this can be a trigger to ensure home aids are installed or provided prior to discharge.

A range of equipment is available and provided as necessary, including grip socks, signs in patient rooms alerting them to stop and call a nurse if they want to mobilise, falls alarms, raised toilet seats, shower seats and walking aids.

Environmental audits are done to assess if lighting is adequate, to ensure areas are not cluttered and, at a patient-specific level, ensure the bed height is appropriate and there is night lighting as required.

Communicating with patients and carers

A range of patient information on falls risk and prevention was sighted by the survey team, including the July 2017 “Keeping a step ahead of falls”, which is noted to be a consumer approved publication. Such documents have a symbol on the back page to confirm this is the case. There are also Occupational Therapy - specific patient information about falls. Patient information is included in patients' admission/ orientation folders. A new video regarding falls is provided for patients to watch on their bedside televisions.

Consumers sign their clinical pathway forms (care plans), which includes mobility. An audit to show patients are signing was sighted and is highly compliant.

Organisation : Mount Hospital
Orgcode : 521765

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

Organisation : Mount Hospital
Orgcode : 521765

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 11
SERVICE DELIVERY

Surveyor Summary

Information about services

There is a vast range of patient and community information about the services provided at Mount Hospital. A variety of modalities such as the MyHealthscope Website, Mount Hospital Website and Facebook page, patient information brochures which include patient rights and responsibilities and how to provide feedback on services and care provided, are used to disseminate information to the community, patients and carers.

Pre-admission information includes access to services through the organisation including advocacy.

Evidence of evaluation of the information provided and means of dissemination has been used by the hospital and the Consumer Advisory Committee to regularly improve information provided.

Communication with VMO and external service providers was clearly evident.

Access and admission to services

The Hospital Access Manager (HAM) and the After-Hours Manager (AHM) are responsible for the prioritisation and admission process for all patients. MH2.1 Policy identifies exclusion criteria for Mount Hospital. Admissions are generally elective and planned; however, there is a Priority Admission Services for patients suffering chest pain or shortness of breath, who are admitted via the patient's cardiologist. Patients complete a pre-admission history which is used to risk assess and identify additional assessments, including anaesthetic risk assessment, prior to admission. A daily meeting of the DON, HAM and Operating Theatre Manager tracks all admissions, bed allocation and scheduled theatre time to ensure all patient identified special requirements and needs are met. There is no waiting list for admission.

Consumer / patient consent

Patient consent is obtained for all relevant procedures including blood transfusion, surgical procedures, cardiac catheterisation, and organ donation. Interpreters are available if required to assist with the patients' understanding of the process.

Audits of compliance with the consent policy is of a very high level. Theatres will not accept any patient that does not have appropriate consent. It is suggested that the process of gaining consent for chemotherapy be formalised and linked to the development of medication management plans for such patients.

Appropriate and effective care

Patients were nursed in appropriate areas of the facility. Patient outliers were provided with nurses seconded from the "home" ward. Guidelines for care in regard to anti-coagulation therapy, atrial fibrillation, and chemotherapy were available as were the standard clinical pathways.

The clinical governance and quality committee structure of the hospital helps to ensure appropriate care.

Organisation : Mount Hospital
Orgcode : 521765

Diverse needs and diverse backgrounds

The demographic profile of Mount Hospital is regularly assessed with the majority of patients being from an English-speaking background. Interpreter services are available, and the use of access is monitored. Issues have occurred because of cultural differences. Resolution is promptly resolved utilising the organisation's strong partnerships with local community services and links with the public health sector.

Population health

Health promotion activities are embedded into the organisation's mainstream services; these include participation in regular events such as hand hygiene awareness, fall prevention and on the survey, there was a promotion held for the prevention of venous thromboembolism (VTE).

Organisation : Mount Hospital
Orgcode : 521765

Information about services

Ratings

Action	Organisation	Surveyor
11.1.1	SM	SM
11.1.2	SM	SM
11.2.1	SM	SM
11.2.2	SM	SM

Access and admission to services

Ratings

Action	Organisation	Surveyor
11.3.1	SM	SM

Consumer / Patient Consent

Ratings

Action	Organisation	Surveyor
11.4.1	SM	SM
11.4.2	SM	SM

Appropriate and effective care

Ratings

Action	Organisation	Surveyor
11.5.1	SM	SM
11.5.2	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

Diverse needs and diverse backgrounds

Ratings

Action	Organisation	Surveyor
11.6.1	SM	SM
11.7.1	SM	SM
11.7.2	SM	SM

Population health

Ratings

Action	Organisation	Surveyor
11.8.1	SM	SM
11.9.1	SM	SM
11.9.2	SM	SM
11.10.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 12
PROVISION OF CARE

Surveyor Summary

Assessment and care planning

Evidence-based guidelines are available and accessible on the intranet (HINT) to ensure the care planning assess physical, spiritual, cultural, psychological and social needs of the patient.

Similarly, guidelines to meet the specific health needs of self-identified Aboriginal and Torres Strait Islander (ATSI) patients and their carers are available for staff on the HINT. More recently the need to access this information was required for an admitted patient. This has highlighted the need for more formal awareness training of clinical NUMs and Educators to ensure support is available as required for all staff in meeting the health care needs of Aboriginal and Torres Strait Islander patients.

Management of nutrition

A multidisciplinary Nutritional Governance Group has been established to oversee the management of nutrition in accordance with relevant Healthscope and Mount Hospital nutrition related policies. A Malnutrition Screening tool has been implemented and staff training provided in completion of this risk tool. All patients identified as being a moderate to high risk are required to be referred to the dietitian. These referrals currently relate to 25% of admitted patients.

Audit results have resulted in a number of improvements including the use of a ‘Red Tray’ to identify patient needs for assistance with meals.

Ongoing care and discharge / transfer

At time of discharge the Discharge Planner meets with the patient and discusses the discharge arrangements for all patients other than day only patients. A Nursing Discharge Summary is provided to the patient and the local medical officer. Information such as fall risk and falls management is conveyed through this mechanism.

The Discharge Planner assists in organising ongoing care and with any arrangement for re-admission where appropriate.

End-of-life care

There are the relevant policies in place for the management of end-of-life care. These include the access and utilisation of Advance Care Health Directives. The hospital and in particular the Discharge Planner has links to the nearby Hospice, and to community palliative care services.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Assessment and care planning

Ratings

Action	Organisation	Surveyor
12.1.1	SM	SM
12.1.2	SM	SM
12.2.1	SM	SM
12.2.2	SM	SM
12.3.1	SM	SM
12.4.1	SM	SM

Management of nutrition

Ratings

Action	Organisation	Surveyor
12.5.1	SM	SM
12.5.2	SM	SM
12.6.1	SM	SM
12.6.2	SM	SM
12.6.3	SM	SM
12.7.1	SM	SM
12.7.2	SM	SM

Ongoing care and discharge / transfer

Ratings

Action	Organisation	Surveyor
12.8.1	SM	SM
12.8.2	SM	SM
12.8.3	SM	SM
12.9.1	SM	SM
12.10.1	SM	SM
12.10.2	SM	SM
12.10.3	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

End-of-life care

Ratings

Action	Organisation	Surveyor
12.11.1	SM	SM
12.11.2	SM	SM
12.12.1	SM	SM
12.12.2	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 13
WORKFORCE PLANNING AND MANAGEMENT

Surveyor Summary

Workforce planning

The policies and procedures for workforce planning are up to date. Contingency plans are also in place to ensure staffing for such areas as the cardiac catheter laboratory services, oncology services, and supervisory and managerial staffing.

Recruitment processes

Compliance with current legislation and regulations is overseen by Healthscope Corporate Office. The credentialing systems for the clinical staff are fully functional and effective.

Volunteer staff members undergo a vetting process on the same basis as the employed staff members, and are required to attend orientation and other mandatory training programs. Appraisal of the volunteers is also in place.

Continuing employment and development

Staff members' personnel records are kept in the Executive area in a secure manner. There is a register maintained of staff member attendances at training and education programs and courses. Performance development system is based on an annual appraisal of staff members and there are three formats of the tools available so that the tool is tailored to the staff member's role.

The survey team noted that in a recent event of an issue in regard to a clinician, there was strong support provided by the hospital to staff members.

Employee support and workplace relations

The rights and responsibilities are outlined in the Healthscope employment contract documents. Staff employment arrangements of an industrial nature were covered by an Enterprise Bargaining Agreement (EBA). Staff members have access to an Employee Assistance Program (EAP) provided by the hospital when necessary. The survey team noted the high morale of the staff members at Mount Hospital and that their motivation was easy to discern. Staff awards acknowledging good work practices are in place.

Organisation : Mount Hospital
Orgcode : 521765

Workforce planning

Ratings

Action	Organisation	Surveyor
13.1.1	SM	SM
13.1.2	SM	SM
13.2.1	SM	SM
13.3.1	SM	SM

Recruitment processes

Ratings

Action	Organisation	Surveyor
13.4.1	SM	SM
13.5.1	SM	SM
13.5.2	SM	SM
13.6.1	SM	SM

Continuing employment and development

Ratings

Action	Organisation	Surveyor
13.7.1	SM	SM
13.7.2	SM	SM
13.8.1	SM	SM
13.8.2	SM	SM
13.8.3	SM	SM
13.9.1	SM	SM
13.9.2	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

Employee support and workplace relations

Ratings

Action	Organisation	Surveyor
13.10.1	SM	SM
13.10.2	SM	SM
13.11.1	SM	SM
13.12.1	SM	SM
13.13.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 14
INFORMATION MANAGEMENT

Surveyor Summary

Health records management

Mount Hospital has a range of policies and procedures to support the management of patient health records which cover the requirement for legislative and Australian Standards compliance. Staff are provided education on records management at orientation. Currently, health records are paper based and are stored in an on-site compactus. File culling is currently a shared role within the patient information clerical staff.

Single patient identifiers are present with systems to monitor for multiple file creations. There is a process to monitor and merge files under the direction of the Health Information Manager.

The retention and disposal of medical records is as per the Western Australian Retention and Disposal schedule for both clinical and corporate records with an internal policy to complement this process. Files are kept on-site for up to 18 months then stored off-site. A recent audit demonstrated that 100% of files retrieved from the external storage service were delivered on the same day. Urgent files can be retrieved sooner if required.

The Medical Records Department is staffed Monday to Friday. After hours, the Nurse Managers in charge have access for patient admission during these times. The department is fully secured. Records between 1980 to March 1996 are Microfiched and are available on-site. There is a policy to assist with the management of Microfiche files.

Staff are educated on how to order medical records either by phone or ordered electronically through the patient administration management system. WebPAS is the patient administration management system, the primary source of patient reference data used at Mount Hospital. Clinicians can access appropriate and timely information regarding previous patient admission as well as file retrieval. The clinical record can be requested by the specialist to have available for use in their clinic, thereby ensuring continuity of care. There is a dedicated clerk responsible to support this process.

Clinical coding occurs on-site. Coders have attended some internal clinical meetings to assist with interpretation of new procedures that are recorded in the health record to link with the relevant code.

Policies and procedures are established to assist with the management of consumer requests for access to their health records. These are assessed individually by the Director of Nursing and the General Manager. Information is provided to the patient in the general admission pamphlets and there are smaller pamphlets available on wards and department display holders.

Corporate records management

There is an array of policies and procedures to manage corporate records. These include the management of manual files, file retention and destruction, the use of emails, and personnel files. Issues with processes for the management of files for financial, payroll and human resources are delineated and secure. Staff are provided with information on Health Records Management at orientation and provided with copies of the Mount Hospital Code of Conduct and Confidentiality policies.

Organisation : Mount Hospital
Orgcode : 521765

Collection, use and storage of information

Identification and planning of the organisation's need for information is ongoing. It is dependent on the department and report required as to where and when the report is generated. The analysis of data occurs across the organisation with reporting of information to the Executive and the Medical Advisory Committees as well as for operational needs. External data such as the ACHS clinical indicators are also part of the process of collection and analysis.

Information and communication technology

Policies and procedures have been developed by Healthscope for the management of information and communication technology (ICT). These include information's security, system development, maintenance, backup procedures, disaster and business continuity preparedness.

Healthscope has several software enterprise agreements with companies that produce Microsoft and WebPAS.

ICT security is monitored, with several security products available for use to limit the introduction of virus, malware and spam. Staff are required to sign an ICT access agreement at the commencement of employment and strict secure password access to systems is maintained and enforced.

Organisation : Mount Hospital
Orgcode : 521765

Health records management

Ratings

Action	Organisation	Surveyor
14.1.1	SM	SM
14.2.1	SM	SM
14.3.1	SM	SM
14.3.2	SM	SM
14.4.1	SM	SM

Corporate records management

Ratings

Action	Organisation	Surveyor
14.5.1	SM	SM

Collection, use and storage of information

Ratings

Action	Organisation	Surveyor
14.6.1	SM	SM
14.6.2	SM	SM
14.7.1	SM	SM
14.8.1	SM	SM

Information and communication technology

Ratings

Action	Organisation	Surveyor
14.9.1	SM	SM
14.9.2	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

STANDARD 15
CORPORATE SYSTEMS AND SAFETY

Surveyor Summary

Strategic and operational planning

The Mount Hospital General Manager works with the State Manager of Healthscope regarding Mount Hospital's strategic planning. Mount Hospital is able to build and promote its own brand. There has been considerable development in the area of cardiac medicine and this is one of the current strategic priorities. Mount Hospital prides itself on being a leading private provider of cardiac services in Western Australia. They are particularly proud of the fact they performed 701 heart surgeries in 2016 and are heading for 800 in 2017.

Mount Hospital plans locally for their service delivery and undertakes local environmental scanning to gain understanding of the needs of the Western Australian community. Input from Department Heads and the Medical Advisory Committee, as well as consumers, helps in the development of strategic and operational plans.

A staff survey was undertaken in late 2016 and subsequently Mount Hospital implemented some strategies to address issues raised, including improved options at the Hudson's Cafe and decluttering the staff room. Ongoing development of action plans is occurring. It was noted that the culture among nurses was not as good as desired in early 2017, but the survey team observed a positive culture, with good engagement and communication of all staff. Staff acknowledged nursing culture had improved and this may be reflected by the addition of new managers and the development of strong executive clinical leadership. The overall culture of Mount Hospital was considered very positive by the survey team.

Systems and delegation practices

There is a Mount Hospital Delegation of Authority policy which outlines responsibilities at an administrative and financial level.

Position descriptions are reviewed yearly and on a position being vacated. A recent example of this is where the Communications Manager left, a new position of Business Development Manager was created to better address future needs of the Hospital.

Membership on Mount Hospital committees has been more fairly distributed to ensure no one individual is overburdened.

The Executive on-call is restricted to clinical staff, who are able to make clinical and operational decisions. Mount Hospital have access to Healthscope Corporate Office in the instance of any contentious or ethical issues, and access to legal representatives is available. The Executive on-call is appraised of any risks and contentious issues on an ongoing basis. Should open disclosure be required, the Healthscope policy for Open Disclosure provides that the General Manager and Director of Nursing are informed and a decision to disclose must consider whether the General Manager/ Director of Nursing, or medical practitioner is required to prepare for open disclosure.

All committees are measured against key performance indicators, including achievement of objectives and attendance of its members.

Policies regarding all financial management, including capital expenditure, equipment, etc. were sighted by the survey team and outline the delegation of limits on expenditure, reference to other policies, legislation and the Australian Securities Commission Corporations Law, among others. The Executive, Unit Managers and Healthscope Corporate Office receive regular balance sheets and achievement against key performance indicators.

External service providers

Service level agreements with external providers were sighted by the survey team, including Spotless Linen and others. They include key performance indicators, such as linen not being damaged or stained, monthly bacterial culture testing to show that linen conforms to a high standard. An example of how a cleaning issue was resolved was provided as evidence to the survey team.

The Healthscope corporate legal team assists in the development of service level agreements.

Research governance

The Healthscope policy on research states that research is not part of core business for Mount Hospital. However, Mount Hospital has a formal agreement with a research facility, which outlines responsibilities and indemnities. This was recently updated in May 2017. Terms of reference of the Bellberry Human Research Ethic Committee were sighted which provides for independent, competent and timely review of research projects in accordance with the National Statement on Ethical Conduct in Human Research.

Minutes from the Consumer Advisory Committee in December 2016 show discussion and involvement of consumers in the development of a Patient Journey Project. This has been identified as a large project and is to be prefaced by some internal quality work. At the next survey, the survey team will be interested to see how this is progressing.

Safety management systems

The Healthscope policy 6.01 for work health and safety covers staff, contractors and third parties. This policy references relevant sub-policies and procedures, such as for manual handling and injury management which were provided as evidence to the survey team. An injury management flowchart is available which covers return to work programs. An example of a return to work program was provided as evidence of current practice.

A July 2017 report “Safety Evaluation, Enhancement and Development Program” was reviewed by the survey team. This report was provided by an external agency, EHS Strategic Solutions, who undertook an on-site review on the 12th and 13th July 2017. An action plan was developed with priorities for the immediate and longer terms. Examples of recommendations include the development of a work health and safety strategic plan, raising the awareness and encouraging the reporting of hazards. One action within the plan is the development of an environmental audit tool and occupational safety and health officers have been trained in its use. Another priority was to increase workplace health and safety visibility. The Occupational Safety and Health Committee minutes were reviewed by the survey team and discussion around the action plan is evident.

The risk register includes risks for workplace health and safety, such as external disaster management and post-incident recovery.

Safety and health representatives undergo a course and refresher training provided by Training Services Australia and the survey team reviewed the training attendance register. Compliance with this and other workplace health and safety courses, including non-clinical manual handling and emergency procedures, is very high.

Mount Hospital keeps a register of hazardous and dangerous substances and material safety data sheets, which were provided as evidence for the survey team. All were shown to have currency and are reviewed regularly.

Healthscope has engaged Gammatronics Pty Ltd to oversee radiation safety at Mount Hospital. There is a safety management plan which is guided by a radiation safety policy which was reviewed in September 2017. The Radiation Safety and Protection Plan dated March 2017, was reviewed by the survey team and includes, but not limited to, hazard assessment, dose limits, responsibilities of the registrant, duties of the radiation safety officer and employees, training and remedial procedures. The training schedule was sighted by surveyors and there is a mix of staff who have either completed or are scheduled for training.

It was noted that Formalin is decanted into buckets in the specimen room in the operating theatre suite. The survey team identified the practice as a risk and the reader is referred to the Surveyor Summary for Standard 3 for further information, where a suggestion has been made.

Buildings, plant and equipment

Mount Hospital uses a software program KwikLook for its maintenance system. This is used to log jobs and also to produce and maintain maintenance schedules. Examples of procurement approvals for medical equipment and consumables were provided to the survey team as were maintenance jobs and testing of equipment, such as lead gown service records and testing of registered irradiating apparatus and electronic products.

The risk register includes examples of incidents, including when a member of staff was injured when a door was opened as the in-door window did not allow for a clear view. Remedial action of replacing tinted for clear glass was implemented. Other examples, such as replacement of safety steps when irreparable and fitting of handrails at steps to a staff station on a ward, were provided.

Universal signage symbols are used where necessary, such as at fire exits. Mount Hospital has identified that 91% of its clients are from English speaking backgrounds, so written signage is in English; however, resources in languages other than English are available to staff on the shared electronic drive if needed.

Emergency and disaster management

Mount Hospital has a Business Continuity Plan which was sighted by the survey team and includes risks around fire, clinical equipment failure, sewerage problems etc. The Emergency Procedure Manual was last reviewed in June 2017.

Mock emergency procedure drills are carried out, including evacuation. Staff in all departments are trained in emergency responses and compliance rates for training are very high.

Mount Hospital had a geotechnical surveyor review the escarpment at the rear of the hospital which abuts Kings Park and the Botanical Gardens to ensure it was stable. Mount Hospital work with the Department of Fire and Emergency Services and the Kings Park and Botanical Gardens Board yearly regarding the vegetation at the rear of its grounds and bush fire management. The Hospital would be notified immediately should a bush fire occur in Kings Park.

Organisation : Mount Hospital
Orgcode : 521765

The WA Health Licensing and Accreditation Regulatory Unit (LARU) surveyed Mount Hospital and identified risks regarding the storage of beds in a fire exit. An action plan is in place for education and training of staff to ensure all fire exits are accessible and allow easy egress. The survey team also sighted the current annual fire report which identified that annual fire mode testing and testing fire dampers and stairwell systems had not been completed. It was noted initially, prior to survey, that the annual fire mode testing could not be completed until the Mount Hospital Fire Matrix Plan is completed. An action plan has been developed following this review and evidence of external contractors undertaking fire mode testing and testing fire dampers and stairwell systems has been completed. The Fire Matrix Plan involves the staged mechanical replacement of the smoke exhaust fans, smoke handling and stair pressurisation systems. This work is scheduled for completion by 30th June 2018. It will be important for Mount Hospital to provide evidence to the survey team at the next accreditation survey.

Mount Hospital is to meet with the hospital's refurbishment project consultant's PDA and Healthscope National Projects Manager in October 2017.

Physical and personal security

A workplace health and safety risk assessment and training needs analysis was completed in September 2017. Staff safety is viewed as a high risk. All staff are trained in workplace aggression and violence. Mount Hospital has high compliance for completion of the training. Policies for aggression management and violence were reviewed and are current.

Staff are provided with a free shuttle bus to a staff car park located off site. The staff are dropped off by their vehicle, rather than at the entrance to the car park.

There are 22 cameras around the external and internal environment of Mount Hospital, mainly around entry and egress sites. Recordings are kept for one month and a review is currently underway to see if this can be extended. Should it be required before any vision is removed, copies can be made.

Car parks on-site have swipe card access as are doors to certain clinical areas. Anti-tamper plates are on door locks.

Mount Hospital used to have a contract to provide security services. Due to the low incidence of security incidents this did not continue. However, there have been a couple of recent incidents of a break-in and attempted break-in to vehicles in the doctors' car park, which have occurred between midnight and 6.00 am. Mount Hospital has engaged an external agency to do some short-term ad hoc security monitoring.

Waste and environmental management

Mount Hospital's 2015 policy Waste Management includes requirements for waste minimisation and recycling, waste containers, handling, containment, transport and storage. Various external contractors support Mount Hospital with its waste and environmental management, including clinical and general waste, sharps disposal and cytotoxic substance removal. Surveyors were provided with copies of Licences and service level agreements.

Daily checklists are used for the routine management of waste. There is a comprehensive waste management plan which covers the clinical, cytotoxic, pharmaceutical, chemical, radioactive, recyclable, organic, liquid and general waste.

Requirements for safe work practices including the use of personal protective equipment and spill management for hazardous substances are well documented.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Waste audits were provided as evidence for the survey, including one in 2017 from an external provider, Daniels, who audited sharps waste containers and clinical waste. The audit made recommendations as not all sharps containers were filled to capacity. Clinical waste segregation was to a high standard.

To increase the efficient use of energy and reduce costs, Mount Hospital is replacing dichromatic down lights with LED lighting. Sensor lighting have been introduced in to newer sections of the operating theatre, recovery and CSSD and utility rooms. Fluorescent lighting in consulting suites have been replaced with single dome LED lights.

Mount Hospital is looking at other strategies to make efficiencies and improve environmental stability, including kitchen exhaust and supply upgrades, rain water harvesting, dialysis water recycling, room tap upgrades and sewage discharge factor reductions. Mount Hospital does not burn anything on-site.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Strategic and operational planning

Ratings

Action	Organisation	Surveyor
15.1.1	SM	SM
15.1.2	SM	SM
15.1.3	SM	SM
15.2.1	SM	SM
15.2.2	SM	SM

Systems and delegation practices

Ratings

Action	Organisation	Surveyor
15.3.1	SM	SM
15.4.1	SM	SM
15.5.1	SM	SM
15.6.1	SM	SM
15.7.1	SM	SM
15.8.1	SM	SM

External Service Providers

Ratings

Action	Organisation	Surveyor
15.9.1	SM	SM
15.9.2	SM	SM

Research Governance

Ratings

Action	Organisation	Surveyor
15.10.1	SM	SM
15.10.2	SM	SM
15.11.1	SM	SM

15.11.2	SM	SM

Safety management systems

Ratings

Action	Organisation	Surveyor
15.12.1	SM	SM
15.13.1	SM	SM
15.13.2	SM	SM
15.13.3	SM	SM
15.14.1	SM	SM

Buildings, plant and equipment

Ratings

Action	Organisation	Surveyor
15.15.1	SM	SM
15.15.2	SM	SM
15.16.1	SM	SM
15.16.2	SM	SM
15.17.1	SM	SM

Emergency and disaster management

Ratings

Action	Organisation	Surveyor
15.18.1	SM	SM
15.19.1	SM	SM
15.20.1	SM	SM
15.20.2	SM	SM

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Physical and personal security

Ratings

Action	Organisation	Surveyor
15.21.1	SM	SM
15.21.2	SM	SM
15.22.1	SM	SM
15.22.2	SM	SM
15.23.1	SM	SM

Waste and environmental management

Ratings

Action	Organisation	Surveyor
15.24.1	SM	SM
15.25.1	SM	SM
15.26.1	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

	procedures with invasive devices		
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and	SM	SM

	comprehensive list of medicines and explanation of changes in medicines		
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	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

Organisation : Mount Hospital
Orgcode : 521765

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

Organisation : Mount Hospital
Orgcode : 521765

Blood and Blood Products

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

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

Documenting patient information

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

Managing blood and blood product safety

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

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Service Delivery

Information about services

Action	Description	Organisation's self-rating	Surveyor Rating
11.1.1	There is evidence of evaluation and improvement of the quality of information provided to consumers / patients and the community about: • services provided by the organisation • access to support services, including advocacy.	SM	SM

11.1.2	The organisation’s processes for disseminating information on healthcare services are evaluated, and improved as required.	SM	SM
11.2.1	Healthcare providers within the organisation have information on relevant external services.	SM	SM
11.2.2	Relevant external service providers are provided with information on the health service and are informed of referral and entry processes.	SM	SM

Access and admission to services

Action	Description	Organisation's self-rating	Surveyor Rating
11.3.1	The organisation evaluates and improves its system for admission / entry and prioritisation of care, which includes: • documented processes for prioritisation • clear inclusion and/or exclusion criteria • management of waiting lists • minimisation of duplication • utilisation of information in referral documents from other service providers received on admission of the consumer / patient • management of access block.	SM	SM

Consumer / Patient Consent

Action	Description	Organisation's self-rating	Surveyor Rating
11.4.1	The organisation has implemented policies and procedures that address: • how consent is obtained • situations where implied consent is acceptable • situations where consent is unable to be given • when consent is not required • the limits of consent.	SM	SM
11.4.2	The consent system is evaluated, and improved as required.	SM	SM

Appropriate and effective care

Action	Description	Organisation's self-rating	Surveyor Rating
11.5.1	The organisation ensures appropriate and effective care through: • processes used to assess the appropriateness of care • an evaluation of the appropriateness of services provided • the involvement of clinicians, managers and consumers / patients in the evaluation of care and services.	SM	SM
11.5.2	Policy / guidelines are implemented that address the appropriateness of the setting in which care is provided including when consumers / patients are accommodated outside the specialty ward area.	SM	SM

Diverse needs and diverse backgrounds

Action	Description	Organisation's self-rating	Surveyor Rating
11.6.1	The organisation obtains demographic data to: • identify the diverse needs and diverse backgrounds of consumers /	SM	SM

	patients and carers • monitor and improve access to appropriate services • improve cultural competence, awareness and safety.		
11.7.1	Policies and procedures that consider cultural and spiritual needs are implemented to ensure that care, services and food are provided in a manner that is appropriate to consumers / patients with diverse needs and from diverse backgrounds.	SM	SM
11.7.2	Mechanisms are implemented to improve the delivery of care to diverse populations through: • demonstrated partnerships with local and national organisations • providing staff with opportunities for training.	SM	SM

Population health

Action	Description	Organisation's self-rating	Surveyor Rating
11.8.1	Performance measures are developed, and quantitative and/or qualitative data collected, to evaluate the effectiveness / outcomes of health promotion programs and interventions implemented by the organisation.	SM	SM
11.9.1	The organisation identifies and responds to emerging health trends.	SM	SM
11.9.2	The organisation meets its legislative requirements for reporting on public health matters.	SM	SM
11.10.1	There is evidence of evaluation and improvement of strategies to promote better health and wellbeing, which include: • undertaking opportunistic health promotion / education strategies in partnership with consumers / patients, carers, staff and the community • providing education, training and resources for staff to support the development of evidence-based health promotion programs and interventions.	SM	SM

Provision of Care

Assessment and care planning

Action	Description	Organisation's self-rating	Surveyor Rating
12.1.1	Guidelines are available and accessible by staff to assess physical, spiritual, cultural, psychological and social, and health promotion needs.	SM	SM
12.1.2	Guidelines are available and accessible by staff on the specific health needs of self-identified Aboriginal and Torres Strait Islander consumers / patients.	SM	SM
12.2.1	The assessment process is evaluated to ensure that it includes: • timely assessment with consumer / patient and, where appropriate, carer participation • regular assessment of the consumer / patient need for pain / symptom management • provision of information to the consumer / patient on their health status.	SM	SM
12.2.2	Referral systems to other relevant service providers are evaluated, and improved as required.	SM	SM

12.3.1	Care planning and delivery are evaluated to ensure that they are: • effective • comprehensive • multidisciplinary • informed by assessment • documented in the health record • carried out with consumer / patient consent and, where appropriate, carer participation.	SM	SM
12.4.1	Planning for discharge / transfer of care is evaluated to ensure that it: • commences at assessment • is coordinated • consistently occurs • is multidisciplinary where appropriate • meets consumer / patient and carer needs.	SM	SM

Management of nutrition

Action	Description	Organisation's self-rating	Surveyor Rating
12.5.1	Policy / guidelines for: • delivery of nutritional care • prevention of malnutrition • assessment of need for assistance with meals are consistent with jurisdictional guidelines, adapted to local needs and implemented across the organisation.	SM	SM
12.5.2	The organisation’s strategic and coordinated approach to delivering consumer / patient-centred nutritional care is evaluated, and improved as required.	SM	SM
12.6.1	Food, fluid and nutritional care form part of an intervention and clinical treatment plan.	SM	SM
12.6.2	Relevant healthcare providers use an approved nutrition risk screening tool to assess consumers / patients: • on admission • following a change of health status • weekly thereafter and referrals to nutrition-related services occur when needed.	SM	SM
12.6.3	The adequacy of consumer / patient nutrition is actively monitored and reported, and improvement is made to the nutritional care as required.	SM	SM
12.7.1	A multidisciplinary team oversees the organisation’s nutrition management strategy to ensure that provision of food and fluid to consumers / patients is consistent with best-practice nutritional care.	SM	SM
12.7.2	Education programs for relevant staff about their roles and responsibilities for delivering best-practice nutritional care and preventing malnutrition are evaluated, and improved as required.	SM	SM

Ongoing care and discharge / transfer

Action	Description	Organisation's self-rating	Surveyor Rating
12.8.1	Discharge / transfer information is discussed with the consumer / patient and a written discharge summary and/or discharge	SM	SM

	instructions are provided.		
12.8.2	Arrangements with other service providers and, where appropriate, the carer are made with consumer / patient consent and input, and confirmed prior to discharge / transfer of care.	SM	SM
12.8.3	Results of investigations follow the consumer / patient through the referral system.	SM	SM
12.9.1	Formalised follow up occurs for identified at-risk consumers / patients.	SM	SM
12.10.1	Formal processes for timely, multidisciplinary care coordination and/or case management for consumers / patients with ongoing care needs are evaluated, and improved as required.	SM	SM
12.10.2	Systems for screening and prioritising consumers / patients with ongoing care needs who regularly require readmission are evaluated, and improved as required.	SM	SM
12.10.3	Education is provided to consumers / patients requiring ongoing care and, where appropriate, to their carers.	SM	SM

End-of-life care

Action	Description	Organisation's self-rating	Surveyor Rating
12.11.1	Policy and procedures for the management of consumer / patient end-of-life care consistent with jurisdictional legislation, policy and common law are available and staff receive relevant education.	SM	SM
12.11.2	There is policy / guidelines for supporting staff, consumers / patients and carers involved in organ and tissue donation.	SM	SM
12.12.1	Access to and effectiveness of end-of-life care is evaluated, including through the use of clinical review committees.	SM	SM
12.12.2	A support system is used to assist staff, relatives, carers and consumers / patients affected by a death.	SM	SM

Workforce Planning and Management

Workforce planning

Action	Description	Organisation's self-rating	Surveyor Rating
13.1.1	Workforce management functions and responsibilities are clearly identified and documented.	SM	SM
13.1.2	The workforce policy, procedures, plan, goals and strategic direction are regularly reviewed, evaluated, and improved as required.	SM	SM
13.2.1	Contingency plans are developed to maintain safe, quality care if prescribed levels of skill mix of clinical and support staff are not available, and in order to manage workforce shortages.	SM	SM
13.3.1	The system for managing safe working hours and fatigue prevention is evaluated, and improved as required.	SM	SM

Recruitment processes

Action	Description	Organisation's self-rating	Surveyor Rating
13.4.1	The organisation-wide recruitment, selection and appointment systems are evaluated, and adapted to changing service needs where	SM	SM

	required.		
13.5.1	Recruitment processes ensure adequate staff numbers and that the workforce has the necessary licences, registration, qualifications, skills and experience to perform its work.	SM	SM
13.5.2	The credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians, which is consistent with national standards and guidelines and with organisational policy, is evaluated, and improved as required.	SM	SM
13.6.1	The volunteer recruitment system supports an adequate number and mix of volunteers to complement the work undertaken by paid staff.	SM	SM

Continuing employment and development

Action	Description	Organisation's self-rating	Surveyor Rating
13.7.1	Accurate and complete personnel records, including training records, are maintained and kept confidential.	SM	SM
13.7.2	There is a system to document training for staff and volunteers which is identified as necessary by the organisation.	SM	SM
13.8.1	The performance assessment and development system includes: • review of position descriptions • review of competencies • monitoring of compliance with published codes of professional practice • assessment of learning and development needs • provision of adequate resources for learning and development • management of identified performance needs.	SM	SM
13.8.2	Ongoing monitoring and review of clinicians' performance is linked to the credentialling system.	SM	SM
13.8.3	The performance assessment and development system is evaluated through appropriate stakeholder consultation, and improved as required.	SM	SM
13.9.1	Processes are in place for managing a complaint or concern about a clinician, and there is evidence that they have been used.	SM	SM
13.9.2	Processes are in place for managing a complaint or concern about a member of staff, including contracted staff and volunteers, and there is evidence they have been used.	SM	SM

Employee support and workplace relations

Action	Description	Organisation's self-rating	Surveyor Rating
13.10.1	The workplace rights and responsibilities of management, staff and volunteers are clearly defined and communicated.	SM	SM
13.10.2	Managers take action on at-risk behaviour of staff and volunteers.	SM	SM
13.11.1	There is a consultative and transparent system to identify, manage and resolve workplace relations issues which is evaluated, and improved as required.	SM	SM
13.12.1	Strategies to: • motivate staff • acknowledge the value of staff • support flexible work practices	SM	SM

	are evaluated with staff participation, and improved as required.		
13.13.1	Performance measures are used regularly to assess staff access to an employee assistance program and to evaluate the staff support services, and improvements are made as required.	SM	SM

Information Management

Health records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.1.1	Health records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • timely and accurate retrieval of records stored on or off site, or electronically • appropriate retention and destruction of records • training for relevant staff in health records management.	SM	SM
14.2.1	The system for the allocation and maintenance of the organisation-specific consumer / patient identifier, including a process for checking multiple identifiers, is evaluated, and improved as required.	SM	SM
14.3.1	Healthcare workers participate in the analysis of data including clinical classification information.	SM	SM
14.3.2	Clinical coding and reporting time frames that meet internal and external requirements are evaluated, and improved as required.	SM	SM
14.4.1	Consumers / patients are given advice / written guidelines on how to access their health information, and requests for access are met.	SM	SM

Corporate records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.5.1	Corporate records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • standardised record creation and tracking • appropriate retention and destruction of records • training for relevant staff in corporate records management.	SM	SM

Collection, use and storage of information

Action	Description	Organisation's self-rating	Surveyor Rating
14.6.1	Monitoring and analysis of clinical and non-clinical data and information occur to ensure: • accuracy, integrity and completeness • the timeliness of information and reports	SM	SM

	• that the needs of the organisation are met and improvements are made as required.		
14.6.2	The information management system is evaluated to ensure that it includes: • identification of the needs of the organisation at all levels • compliance with professional and statutory requirements for collection, storage and use of data • the validation and protection of data and information • delineation of responsibility and accountability for action on data and information • adequate resourcing for the assessment, analysis and use of data • data storage and retrieval facilitated through effective classification and indexing • contribution to external databases and registers • training of relevant staff in information and data management.	SM	SM
14.7.1	The organisation uses data from external databases and registers for: • research • development • improvement activities • education • corporate and clinical decision making • improvement of care and services.	SM	SM
14.8.1	Staff have access to contemporary reference and resource material.	SM	SM

Information and communication technology

Action	Description	Organisation's self-rating	Surveyor Rating
14.9.1	The ICT system is evaluated to ensure that it includes: • backup • security • redundancy • protection of privacy • virus detection • preventative maintenance and repair • disaster recovery / business continuity • risk and crisis management • monitoring of compliance with ICT policy and procedures.	SM	SM
14.9.2	Licences are purchased as required to ensure intellectual property rights and title to products are retained by product owners.	SM	SM

Corporate Systems and Safety

Strategic and operational planning

Action	Description	Organisation's self-rating	Surveyor Rating
15.1.1	The strategic plan that: • includes vision, mission and values • identifies priority areas for care, service delivery and facility development	SM	SM

	• considers the most efficient use of resources • includes analysis of community needs in the delivery of services • formally recognises relationships with relevant external organisations is regularly reviewed by the governing body.		
15.1.2	Leaders and managers act to promote a positive organisational culture.	SM	SM
15.1.3	Operational plans developed to achieve the organisation's goals and objectives and day-to-day activities comply with appropriate by-laws, articles of association and/or policies and procedures.	SM	SM
15.2.1	Changes driven by the strategic plan are communicated to, and evaluated in consultation with, relevant stakeholders.	SM	SM
15.2.2	Change management strategies are implemented to achieve the objectives of the strategic and operational plans.	SM	SM

Systems and delegation practices

Action	Description	Organisation's self-rating	Surveyor Rating
15.3.1	The processes of governance and the performance of the governing body are evaluated to ensure that they include: • formal orientation and ongoing education for members of the governing body • defined terms of reference, composition and procedures for meetings of the governing body • communication of information about governing body activities and decisions with relevant stakeholders • defined duties and responsibilities and a role for strategy and monitoring.	SM	SM
15.4.1	Compliance with delegations is monitored and evaluated, and improved as required.	SM	SM
15.5.1	Organisational structures and processes are reviewed to ensure that quality services are delivered.	SM	SM
15.6.1	There is evidence of evaluation and improvement of the system to govern and document decision making with ethical implications, which includes: • a nominated consultative body • a process to receive, monitor and assess issues • review of outcomes.	SM	SM
15.7.1	Organisational committees: • have access to terms of reference, membership and procedures • record and confirm minutes and actions of meetings • implement decisions and are evaluated, and improved as required.	SM	SM
15.8.1	The organisation has sound financial management processes that: • are consistent with legislative and government requirements • include budget development and review • allocate resources based on service requirements identified in strategic and operational planning • ensure that useful, timely and accurate financial reports are provided to the governing body and relevant managers • include an external audit.	SM	SM

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

External Service Providers

Action	Description	Organisation's self-rating	Surveyor Rating
15.9.1	There is evidence of evaluation and improvement of systems to manage external service providers, which: • are governed by implemented policy and procedure • include documented service agreements • define dispute resolution mechanisms • monitor compliance of service providers with relevant regulatory requirements and specified standards • require evidence from service providers of internal evaluation of the services they provide • ensure that external service providers comply with organisational policy and procedures.	SM	SM
15.9.2	The organisation evaluates the performance of external service providers through agreed performance measures, including clinical outcomes and financial performance where appropriate, and improvements are made as required.	SM	SM

Research Governance

Action	Description	Organisation's self-rating	Surveyor Rating
15.10.1	The system that: • determines what research requires ethical approval • oversees the ethical conduct of organisational research • monitors the completion of required reporting is evaluated, and improved as required.	SM	SM
15.10.2	Consumers and researchers work in partnership to make decisions about research priorities, policy and practices.	SM	SM
15.11.1	Systems are implemented to effectively govern research through policy / guidelines consistent with: • jurisdictional legislation • key NHMRC statements • codes of conduct • scientific review standards.	SM	SM
15.11.2	The governance of research through: • documented accountability and responsibility • establishing formal agreements with collaborating agencies • adequately resourcing the organisation's human research ethics committee (HREC), where applicable is evaluated, and improved as required.	SM	SM

Safety management systems

Action	Description	Organisation's self-rating	Surveyor Rating
15.12.1	Safety management systems include policies and procedures for: • work health and safety (WHS) • manual handling • injury management • management of dangerous goods and hazardous substances	SM	SM

	• staff education and training in WHS responsibilities.		
15.13.1	The system for ensuring WHS includes: • identification of risks and hazards • documented safe work practices / safety rules for all relevant procedures and tasks in both clinical and non-clinical areas • staff consultation • staff education and provision of information • an injury management program • communication of risks to consumers / patients and visitors and is implemented, evaluated, and improved as required.	SM	SM
15.13.2	Staff with formal WHS responsibilities are appropriately trained.	SM	SM
15.13.3	A register of dangerous goods and hazardous substances is maintained and Material Safety Data Sheets (MSDSs) are available to staff.	SM	SM
15.14.1	There is evidence of evaluation and improvement of the radiation safety management plan, which: • is coordinated with external authorities • includes radiation equipment, a register for all radioactive substances, and safe disposal of all radioactive waste • ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA) • keeps consumer / patient radiation to a minimum whilst maintaining good diagnostic quality • includes a personal radiation monitoring system and any relevant area monitoring.	SM	SM

Buildings, plant and equipment

Action	Description	Organisation's self-rating	Surveyor Rating
15.15.1	The procurement, management, risk reduction and maintenance system includes: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables • workplace design.	SM	SM
15.15.2	Plant and other equipment are installed and operated in accordance with manufacturer specifications, and plant logs are maintained.	SM	SM
15.16.1	Incidents and hazards associated with: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables are documented and evaluated, and action is taken to reduce risk.	SM	SM
15.16.2	The safety and accessibility of buildings / workplaces, and the safe	SM	SM

	and consistent operation of plant and equipment, are evaluated, and improvements are made to reduce risk.		
15.17.1	Access to the organisation is facilitated by: • clear internal and external signage • the use of relevant languages and multilingual / international symbols • the provision of disability access • facility design that meets legislative requirements and/or is based on recognised guidelines.	SM	SM

Emergency and disaster management

Action	Description	Organisation's self-rating	Surveyor Rating
15.18.1	There is evidence of evaluation and improvement of the emergency and disaster management systems, which include: • identification of potential internal and external emergencies and disasters • coordination with relevant external authorities • installation of an appropriate communication system • development of a response, evacuation and relocation plan • display of relevant signage and evacuation routes • planning for business continuity.	SM	SM
15.19.1	There is evidence of evaluation and improvement of staff training and competence in emergency procedures, which includes: • education at orientation • annual training in emergency, evacuation and relocation procedures • regularly conducted emergency practice / drill exercises • the appointment of an appropriately trained fire officer • access to first aid equipment and supplies, and training of relevant staff.	SM	SM
15.20.1	There is documented evidence that an authorised external provider undertakes a full fire report on the premises at least once within each EQuIPNational cycle and/or in accordance with jurisdictional legislation.	SM	SM
15.20.2	There is a documented plan to implement recommendations from the fire inspection.	SM	SM

Physical and personal security

Action	Description	Organisation's self-rating	Surveyor Rating
15.21.1	Service planning includes strategies for security management.	SM	SM
15.21.2	The organisation-wide system to identify and assess security risks, determine priorities and eliminate risks or implement controls is evaluated, and improved as required.	SM	SM
15.22.1	Staff are consulted in decision making that affects organisational and personal risk, and are informed of security risks and responsibilities.	SM	SM
15.22.2	Security management plans are coordinated with relevant external authorities.	SM	SM
15.23.1	The violence and aggression management plan is evaluated to	SM	SM

ensure that it includes:
• policies / procedures for the minimisation and management of violence and aggression
• staff education and training
• appropriate response to incidents.

Waste and environmental management

Action	Description	Organisation's self-rating	Surveyor Rating
15.24.1	The waste and environmental management system is evaluated to ensure that it includes: • development and implementation of policy • coordination with external authorities • staff instruction and provision of information on their responsibilities.	SM	SM
15.25.1	Controls are implemented to manage: • identification • handling • separation and segregation of clinical, radioactive, hazardous and non-clinical waste, and the controls are evaluated, and improved as required.	SM	SM
15.26.1	The system to: • increase the efficiency of energy and water use • improve environmental sustainability • reduce carbon emissions is evaluated, and improved as required.	SM	SM

Organisation : Mount Hospital
Orgcode : 521765

Recommendations from Current Survey

Not applicable.

Organisation : Mount Hospital
Orgcode : 521765

Recommendations from Previous Survey

Standard: Medication Safety
Criterion: Documentation of patient information
Action: 4.6.2 The medication history and current clinical information is available at the point of care

Recommendation: EN OWS 0813.4.6.2

Recommendation:

Comply with governing legislation and regulatory requirements.

Action:

There continues to be a strong focus on trying to ensure that medical practitioners sign verbal medication orders within 24 hours which has resulted in steady improvement in compliance over time.

The following strategies have continued:

1. There has been regular auditing of medication charts to check the signing of verbal medication orders.

2. The results of the audits have been discussed at the Drug and Pharmacy Committee and by the General Manager and Medical Director and have been referred to the Medical Advisory Committee for review. At their request electronic options for the signing of verbal medication orders have been explored but no satisfactory tool has been identified.

3. Letters have been sent, with the support of the Medical Advisory Committee, to VMOs who have been identified as non-compliant in the audits, to remind them that it is a legislative requirement to sign verbal medication orders. The General Manager has also spoken personally with the main offenders.

4. Nurse Unit Managers (NUMs) have ensured that robust processes exist for reminding Visiting Medical Officers (VMOs) of unsigned verbal medication orders. Any verbal medication order is entered on a prompt list which is prominently displayed in the ward and is checked whenever a VMO enters the ward so that he/she can be reminded to sign the verbal medication order.

5. Nurses are reminded only to accept a verbal medication order when absolutely essential

6. Nurses are reminded not to continue to administer medications when 24 hours have elapsed

7. Anaesthetic nurses are reminded to prompt VMOs to sign any verbal pre-medication orders

8. Recovery Room nurses are reminded to prompt VMOs to prescribe regularly used analgesia and anti-emetics before the patient leaves the Recovery Room.

9. Nurses are instructed to take charts to Theatres for signing when accepting verbal orders from anaesthetists on site.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Completion Due By: 10/10/17

Responsibility: General Manager

Organisation Completed: Yes

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

The hospital has achieved an excellent result, having all telephone orders signed off within the time period by the relevant medical officer. Audits in the last few months reveal 100% compliance. This reflects the high priority given by the hospital to achieve this outcome. This recommendation is now closed.

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

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**

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Organisation - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Surveyor - NSQHSS V01

Core

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

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

Developmental

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

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

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

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**

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Surveyor - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	2	0	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**24**	**0**	**24**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	14	0	14
Standard 12	0	14	0	14
Standard 13	0	18	0	18
Standard 14	0	11	0	11
Standard 15	0	30	0	30
Total	**0**	**87**	**0**	**87**

Standard	SM	MM	Total
Standard 11	2	0	2
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**24**	**0**	**24**

Standard	SM	MM	Total
Standard 11	14	0	14
Standard 12	14	0	14
Standard 13	18	0	18
Standard 14	11	0	11
Standard 15	30	0	30
Total	**87**	**0**	**87**

EN OWS

Organisation : Mount Hospital
Orgcode : 521765

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	16	0	16	Met
Standard 12	0	24	0	24	Met
Standard 13	0	20	0	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	39	0	39	Met
Total	**0**	**111**	**0**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	16	0	16	Met
Standard 12	24	0	24	Met
Standard 13	20	0	20	Met
Standard 14	12	0	12	Met
Standard 15	39	0	39	Met
Total	**111**	**0**	**111**	**Met**