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

The National Capital Private Hospital

Garran, ACT

Organisation Code: 82 0 001

Survey Date: 14-16 November 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 on-site survey.

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Survey Report

Survey Overview

National Capital Private Hospital (NCPH) is a 130-bed private hospital co located in the same grounds as The Canberra Hospital and Australian National University Medical School. The facility has a range of medical and surgical specialities that include; cardiothoracic, cardiology, orthopaedics, neurosurgery, urology, oncology and general and rehabilitation medicine and is owned and operated by Healthscope Ltd. The facility is supported by Healthscope corporate through the provision of policies, guidelines and frameworks and the opportunity to participate in benchmarking with other facilities within Healthscope.

National Capital Private Hospital has experienced a steady growth in activity over the past three years with a 5% growth in the last financial year, 2016-2017. In 2016, a major expansion of the hospital occurred which included an additional three operating theatres, one of which was a hybrid theatre to undertake complex cardiac, vascular and neurosurgery, an 8-bed intensive care unit and a 14-bed coronary care unit. There has also been an increase in acuity with 9,000 ventilated patient hours in the ICU past year, with an intensive care VMO and registrars appointed to provide 24-hour cover.

Approval has been obtained for a further expansion of an additional 18 beds and a new state of the art cardiac catheterisation suite.

It is evident that there is a culture of continuous improvement and patient centred care throughout NCP and that the Executive and staff are striving for excellence in the standard of health care provided.

There were examples of achievements from all of the standards with some of the highlights being:

- four (4) identifiers documented on the menu slip is commended as this ensures that patients are provided with the correct meal and fluids according to their identity and clinical orders.

- The development of a pressure injury prevention assessment specifically for the operating.

There has been good progress made with the implementation of the National Safety and Quality Health Service (NSQHS) Standards with all ten standards meeting all core and developmental actions. There were no recommendations from the previous survey and there are no recommendations from this survey. This is a great achievement for NCPH.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The National Capital Private Hospital (NCPH) is managed by Healthscope, a leading provider of private health care within Australia. There is a well-established system for governance that includes patient safety and quality that is supported by the Healthscope Quality Plan: Clinical Governance Framework and each year NCPH develops its own plan in line with the national plan.

A system for the management of national policies and procedures is in place and well established for both corporate and at the NCPH level, with ongoing review and current information. The policies and procedures are available electronically via the Healthscope Intranet (HINT). Compliance with policy occurs through the monitoring of incidents and regular audits. There is an extensive quality audit timetable and guidelines for reviewing clinical policies.

The National Board and Executive demonstrate a strong commitment to risk and quality while maintaining oversight of a suite of policies, procedures and protocols that are available to staff electronically ensuring they have access across the organisation.

Patient safety and quality is evident in the NCPH's Strategic Plan and is closely aligned to the quality plan. Performance for safety and quality indicator data is monitored by the Quality Committee, the Leadership and Management Committee and the Medical Advisory Committee (MAC). Performance is measured by a suite of Key Performance Indicators with a comprehensive audit schedule. Safety and Quality reports are submitted to Healthscope Corporate on a quarterly basis and performance is benchmarked with other Healthscope hospitals within the peer group. If there is a KPI that is outside the benchmark and action plan is required to be submitted outlining the strategies implemented to improve the results.

Safety and quality roles and responsibilities are well set out in position descriptions. A NCPH organisational chart clearly outlines the reporting lines and responsibilities for staff. Orientation, annual mandatory training and in-service for staff cover important safety and quality requirements and evaluation indicates good attendance and high levels of satisfaction from those attending. There are records available detailing the numbers of the workforce that have completed education and training.

Mandatory training records show that there are high levels, in the high ninety percentages with compliance. Nursing competencies are conduced and compliance is of a high level. These include aseptic technique and medication management. Staff are congratulated on the high compliance with mandatory training.

The risk management system is well established and is overseen by the Executive, it is well supported by a framework, relevant policies, the use of the RiskMan system and staff education regarding risk management. All risks have been rated with the top ten identified, risks are regularly reviewed and have good controls.

Clinical practice

The survey team noted that individual care plans are formulated on the patient's specific needs based on best practice, patients and carers indicated that they had been involved in the formulation of the plan.

The models of care for rehabilitation patients includes multidisciplinary assessment of goal setting, care planning and case reviews.

It was evident that the models of care include discharge planning commencing at the beginning of the episode of care. NCPH has made considerable progress in involving patients and carers in their care across the organisation.

The use of risk assessment tools is included in the pre-admission documentation. Risk assessments include falls, mobility, skin integrity, malnutrition, cognitive status, VTE, allergies and medication risks. Identification and management of patients at risk of harm is incorporated into the admission assessment process.

An effective system for escalating care was well established for patients that deteriorate.

There is a systematic approach to reviewing local and corporate policies, procedures and protocols for management of patient clinical records. Hard copy integrated records and electronic pathology and radiology results are available at the point of care. CHARM electronic system has been implemented in the oncology and infusion unit.

All patients have a unique identifier and there are well developed processes for retrieval and tracking of records. An audit schedule is used to monitor compliance with screening requirements and spread sheets are maintained for key clinical risks including re-admissions, patient falls, pressure injuries and medications errors.

The clinical records reviewed by the surveyors were found to be well documented.

Performance and skills management

NCPH has robust systems for credentialing and scope of practice to ensure the workforce have the necessary skills and experience to fulfil the role they are undertaking. The framework for credentialing and scope of practice by medical staff is provided by the Healthscope By-Laws and the process is overseen by the Medical Advisory Committee. Applicants are required to provide evidence of credentials, referees, verification of insurance and details of the scope of practice sought. An electronic e-credentialling system has been introduced and is able to provide reports on progress with applications.

A system is in place for medical, nursing and allied health registrations to be checked on the AHPRA website. The processes for defining and monitoring the scope of practice for nursing and allied health include the use of position descriptions and monitoring of performance. Processes for monitoring the supervision of clinical staff are well developed.

Processes are in place for the safe introduction of new interventional procedures and are overseen by the Medical Advisory Committee and the Executive.

Performance development has a strong focus that not only ensures the workforce meet their obligations of clinical practice and professional registration but identifies poor performance.

The performance review system for nursing, allied health and support staff is well developed with compliance rates over 95%.

Incident and complaints management

NCPH has a structured incident and complaints management system to ensure all incidents and complaints are responded to and investigated. Complaints are reported through RiskMan with all significant complaints analysed and the outcomes reported to the hospital executive. Complaints are responded to within 24 hours.

Managers and staff interviewed confirmed their awareness of the systems and their individual roles and accountabilities for reporting, investigating and managing clinical and non-clinical incidents and complaints.

Mechanisms are in place for reporting sentinel events to Healthscope Clinical Governance unit and completion of reviews. There was evidence of implementation of Healthscope shared learnings.

The survey team noted an open disclosure policy and training for staff is in place.

Patient rights and engagement

Healthscope utilises the Australian Charter of Healthcare rights. Information regarding the Charter is provided to patients on admission, posters are available within NCPH and are available on the website. Translated information is available via access to brochures and via interpreter if required. Patient satisfaction surveys consistently show that patients receive and understand their rights and responsibilities, with 92% compliance in December 2016.

Bedside patient communication boards are used in all clinical areas, together with clinical handover to facilitate communication with patients and carers.

A system is in place to monitor the management of consent and is audited regularly, with high levels of compliance noted.

Patients are provided with information on Advance Care Directives and including a Healthscope brochure. Alerts have been established for when a patient’s presents with an Advance Care Directive or when treatment limiting orders are commenced during a patient’s episode of care.

Paper based clinical records are stored securely within the Medical Records Department. Access to all electronic applications is via a secure password. All staff undertake privacy training and a privacy policy is available. Privacy and release of information procedures are available to patients with evidence that they access their information in a timely manner.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The governance arrangements for partnering with consumers framework occurs within the NCPH and Healthscope Partnering with Consumers policy. The Consumer Consultants participate in the Leadership and Management committee and Clinical Consultative Committee. The Consumer Consultants have clearly documented position descriptions and undergo an orientation program.

It was very evident that consumers are very active, passionate and involved at NCPH with the involvement in patient rounding and patient experience. The consumer rounding has been very beneficial in identifying areas for improvement. Consumer rounding has a clearly identified process and reporting to the General Manager or senior staff member of any issues that require immediate attention. The involvement of the Consumer Consultants is very impressive.

It was also evident to the surveyors that the consumer consultants have been involved in the review and development of publications and patient information and that the feedback has been incorporated into the document. A Healthscope logo is imprinted on those publications that have been reviewed to indicate that it is Consumer Approved.

Consumer partnership in designing care

NCPH demonstrated the importance of the involvement of consumers in the development and redesign of the health services. This was evident in several projects that indicated person centred care. The Call Bell project had significant consumer involvement and was around any member of the team being able to answer a call bell, not only nursing staff. One of the outcomes for this quality initiative was that call bells were answered in a timely manner and there was also a corresponding decrease in the number of falls. Patients stated that during their stay the responsiveness of staff answering the call bell was 71.6% in 2017 compared to 45% in 2016.

The ‘SHHH – Silent Hospitals Help Heal’ Project also had significant consumer involvement with patients stating through the feedback to consumers that the environment was too noisy. Some of the changes made was a designated rest period with no treatment or appointments, telephone volumes lowered, SHHH signs and a comfort pack containing ear and headphones and a pamphlet. This initiative also resulted in patients stating that during the hospital stay the environment being quiet at night was 72.69% compared with 25% in 2016.

Consumers are involved in the education of staff with consumers presenting at orientation and participating in regular focus groups, it was evident that staff sought the views of consumers and how practice could be improved for the patient.

Consumer partnership in service measurement and evaluation

Processes have been established for providing consumers with safety and quality performance information for NPCH. This include the display of information of the My Healthscope and through the NCPH information in newsletters and at the Quality and Clinical Consultative Committee.

There was considerable evidence that the consumer consultants participated in the measurement and evaluation of services and safety and quality performance as part of their membership on the Quality Committee and Leadership and Management committee, clinical consultative committee and the infection control committee.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

A comprehensive infection prevention and control service is provided at NCPH with support through Healthcare Infection Control Management Resource (HICMR). Staff have access to information via the HICMR portal, which includes; infection prevention and control manuals and toolkits that have been and updated to relevant standards, legislation and best practice references; risk assessment reviews, reports and action plans.

A comprehensive annual audit is conducted by HICMR to identify infection control risks, action plans are developed where there are recommendations. Infection control policies are available via the Healthscope Intranet and also via the HICMR portal, to which NCPH subscribes.

Several quality improvement initiatives have occurred in the last three years that include gap analysis of AS/NZS 4187:2014 Reprocessing of reusable medical devices in health organisations.

Infection prevention and control strategies

A hand hygiene program is in place with compliance consistently higher than the national benchmark, the current compliance being 87%. An online education module is completed by staff with a high compliance of 97% completion. It was noted that there was an abundance of hand gel and signage throughout NCPH regarding encouraging patients and staff to complete hand hygiene. It is impressive that the compliance rate of hand hygiene for medical staff was high, however it was noted that the moments of hand hygiene audited were low. It is suggested that the moments of hand hygiene for medical staff be increased.

A workplace immunisation program is provided that includes an annual influenza vaccination campaign.

Aseptic technique training modules occur via Aseptic Non-Touch Technique (ANTT) online module for clinical staff, the completion compliance of the module is currently 95%. Observational audits for non-touch aseptic technique are regularly conducted and compliance is monitored. All requirements for aseptic technique have been implemented. The surveyors were provided with information of competencies for invasive devices being completed with a compliance rate over 96%.

Managing patients with infections or colonisations

Personal protective equipment (PPE) was available at the point of care with a pack developed for easy storage of the equipment. PPE audits are conducted.

Signage from the Australian Commission for Safety and Quality in Healthcare (ACSQHS) is utilised to identify patients requiring Transmission Based Precautions.

There is a very low rate infection developed at NCPH, with a well-established surveillance and monitoring in place.

Antimicrobial stewardship

There is a robust Antimicrobial Stewardship Program in place with access to guidelines and monitoring of antibiotic use and a clear reporting structure. There is a systematic review and monitoring of antimicrobial usage with an Antimicrobial Stewardship policy in place.

The National Antibiotic Prescribing survey (NAPS) was conducted in September 2017 with a score of 69%, this will provide a baseline for future surveys. A list of antimicrobial restrictions has been identified with processes in place to manage these. There is access to an infectious diseases specialist in regard to antibiotic use.

Cleaning, disinfection and sterilisation

There has been a redevelopment of the Operating theatres with an increase from four theatres to seven theatres from April 2016. The Manager Central Sterilising Department (CSSD) has a Certificate 3 in sterilising and all staff are appropriately qualified.

A gap analysis for AS/NZ 4187:2014 has been completed and forward progress with the plan has occurred. A Management and Quality Instrument tracking system (MaQs) has been implemented and provides a peri-operative instrument management and traceability system. The system provides a live window based software system that facilitates instrument traceability at each point of the reprocessing cycle for the individual reusable medical device. The system also has the ability to record maintenance schedules and instrument quality checks.

There is an environmental cleaning policy in place with regular audits. A robust system for cleaning equipment is in place that meets regulatory standards. There is also a process and checklist for cleaning patient's rooms on discharge and for terminal cleaning.

Communicating with patients and carers

There is a range of information provided to patients regarding infection control and hand hygiene. Patients indicated on the patient satisfaction survey that they had read and seen information and that it was easily understood.

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:

All requirements for aseptic technique have been met with 96% of the clinical workforce having completed training.

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

Action 3.16.1 Core

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

Surveyor Comment:

A gap analysis has been completed for ASNZ 4187 reprocessing of reusable medical devices with forward progress being made to meet requirements.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

A robust governance system exists for the Management of Medication Safety. This provides a reference for enacting the Strategic and Operational Plans in ensuring patient medication safety.

Benchmarking of medication performance is achieved by the Healthscope (HSP) Cluster group. NCPH compares favourably to all KPIs.

The MAC review all medication management related incidents as part of their Committee Terms of Reference.

Policies are in place for the ordering, prescribing, administration, supply and disposal of all medication. The implementation of 'CHARM' has significantly contributed to the reduction of risks in prescribing Chemotherapy along with the implementation of the Medication Chart (PBS) which replaced the NIMC in May 2017. Review and evaluation the impact of this implementation should be considered. Prescriber satisfaction with the chart should also be obtained as part of this evaluation.

Medication administration authorisation is achieved by a register of Prescribers, and a register of Medication Endorsed ENs. Those staff who are not endorsed to administer medications are known to all staff and self-declare.

Medication Incidents are logged into RiskMan and assigned a Risk Rating. These incidents are discussed and available to the highest level of governance.

Those staff who are involved in multiple medication incidents are counselled and performance managed accordingly. Support is provided during these instances.

The Staff Educator provides a supportive role in ensuring that Medication incidents are prevented with gap analysis education and learning packages.

Tall Man Lettering and identification of High Risk Medication has been successfully implemented with staff realising the benefits of this visual aid. User Applied Labels for medications is practised in high risk areas and known to staff.

Online eLearning related to Medication Management is an annual mandatory requirement with all clinicians expected to undertake. Ninety-two percent (92%) of staff have achieved competence. There is a system in place to ensure 100% of all staff achieve this competency.

Medication formularies exist to guide prescribers where high cost medication is required.

There is a plan to commence clinical trials at NCPH which will combine with planned research initiatives particularly with the cardiology / oncology clinical areas.

Medication Chart audits are undertaken with varying compliance rates. The surveyors have suggested that a greater sample size based upon the organisation's separations be considered to ensure accurate data capture and analysis.

Nurse initiated medications are well documented and have been endorsed by the MAC.

Documentation of patient information

Medication histories are obtained prior to patient admission (where able).

Polypharmic patients are assessed for a medication management plan to be conducted by the clinical pharmacist at this time.

Known patient medication allergies are documented on the 'Alert Chart' within the clinical record and a Red Arm Band attached to the patient to act as a visual alert.

Adverse Drug Reactions are not common, however there is a system in place to assess the patient, report and notify the TGA.

Medication management processes

Medication prescribing decision making tools are available at the point of care. e-MIMS, TGA guidelines, AMH injectable and a website for herbal interactions are available resources and known to staff.

Storage of medications complies to legislative requirements. Emergency trolleys and the medication contents are consistent throughout the organisation which assists in reducing the risk of error.

Temperature sensitive medications are labelled and stored effectively with documentation to support the cold chain.

Medication fridges are regularly checked for temperature variances and alarmed.

The procedure for the disposal of medications is documented and staff are aware of the process.

RUM containers are available for the disposal of all medications (excluding narcotics). Narcotic disposal processes (witnessed) are in place.

Continuity of medication management

A comprehensive list of Medications is provided to the patient at discharge by way of a Discharge Letter – authorised by the discharging doctor. Med Profs (Medication Profiles) are provided by the Pharmacist and CMI pamphlets are provided as required.

Medication Management Plans are also provided to the patient and the referrer.

Medication reconciliation occurs at discharge or where medication changes occur.

NCPH participates in the NAPS Audit with data submitted gaining comparable industry results. Use of Surgical Prophylactic Antimicrobials in Orthopaedic Surgery is 67% compliant with a National Rate of 64% of appropriate prescribing. Action plans and education for prescribers to improve this rate of compliance are supported.

Patient/Carer surveys are undertaken to determine if the medication information provided is appropriate with 90% positive response. No changes have been made to this information based upon the satisfaction of this information.

Communicating with patients and carers

Medication information is provided in easy to read formats with consumers activity sought to review this material.

Medication Management Plans are provided to all eligible patients and clinical pharmacists are available for counselling.

Consumers are surveyed as to the benefits and effectiveness of these plans with 90% satisfaction regarding the information received. A specific question relating to the interaction by the pharmacists has been added to the post-op phone call interview which demonstrates >90% satisfaction.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The organisation has adopted a "4 patient identifiers" procedure to assist in the correct identification of all consumers. These four indicators include: UR Number, Date of Birth, Name and Gender.

The staff were able to demonstrate the system of patient identification throughout all points of the patient journey.

The procedure of identifying a person with the same or similar name is well known and these patients, where possible are cared for in different clinical areas to avoid the risk of mismatching.

Processes to transfer care

Effective processes and identification procedures are in place to ensure the safe transfer of patient care. An example of this included the training of the catering staff in patient identification. Catering staff are provided with a meal slip containing the four identifiers to ensure that all patients are identified by name and not room number to ensure correct meals are provided to the correct patient. This is a significant achievement and the surveyors commend this initiative and look forward to the evaluation of this system change.

Processes to match patients and their care

The staff utilises the patient identifiers regularly, including all interactions which require identity matching.

A working party with specific terms of reference is charged with ensuring that patient safety is considered with all clinical interactions.

There have been no incidents of procedural mismatching.

Correct side, site of surgery checklists are present at the Team Time Out prior to surgery along with limb/site marking where appropriate.

The National ID Band is in place for all patients. Clinical staff verify patient identification upon admission at high risk interactions through their patient episode which includes but is not limited to procedures, medication, administration, radiological and pathology investigations, handover and meal deliveries.

Red Arm bands are placed on patients with known allergies/alerts. Red theatre caps are currently being utilised to identify those patients with alerts/allergies. This is currently being trialled and dependent upon the future advice from the Commission on Safety and Quality in HealthCare.

Audits are conducted to ensure that Patient ID is measured with 92% compliance demonstrated in the medical record documentation audit.

Team Time Out has been witnessed and involves patient identification with patient and medical team participation.

Audits are routinely conducted to ensure compliance and affirmation that TTO has occurred and documented on the intra operative record.

Educational sessions related to Patient Identification are provided and have been well attended - 92% attendance rates are noted.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical Handover is governed by robust policies and procedures to ensure patient safety throughout the continuum of their care.

A Clinical Handover working group provide a reference and resource for issues/suggestions related to clinical handover and the transfer of care.

The working group has mandated education for all staff with staff presentations and face-to-face education provided by the clinical educators.

The organisation has adopted the iSoBAR System for its clinical handover and this was witnessed to be working effectively. A computer generated documentation tool is provided to all staff to assist with information required for their shift.

Clinical handover processes

Several methods of clinical handover are utilised at NCPH and are dependent upon the clinical areas and the feedback from staff. A hybrid system of team handover also with bedside handover was witnessed to be effective within the medical ward whilst individual bedside handover works effectively in higher acuity areas.

The staff satisfaction of the handover system in all areas is measured and deemed appropriate for these clinical areas.

Patient transfer is assisted by documents related to clinical handover. These documents follow the patient journey and staff signatures are apparent to demonstrate acceptance and accountability of patient care once the transfer of information is complete. This is particularly apparent when the patient is transferred from Operating Theatre to PACU to Ward/ICU care.

The wardsman is charged with the transfer of patients to the Operating Theatre from the accommodation areas. The staff believe the process has been further enhanced with the wardsman being provided with an original consent (to identify the patient being collected) and with a transfer slip detailing the four (4) identifiers of the patient. Nursing staff do not transfer the patient to the Operating Theatres unless they have been risk assessed as requiring an escort. A pre-operative checklist is completed which replaces verbal handover which is signed by the ward nurse and by the receiving theatre nurse.

The surveyors suggest that this system of wardsman escorting patients to the theatre be risk assessed from time to time to ensure that this process remains appropriate for the casemix and future casemix of NCPH.

Patient and carer involvement in clinical handover

Bedside handover, Team Time Out and the Surgical Safety Checklist all involved the patient and were witnessed throughout the survey. An opportunity for patients to ask questions was also noted.

Clinical Handover incidents are reported, documented, analysed and action plans developed to assist in decreasing further risks. There have been no incidents related to poor/inaccurate clinical handover in the past two years. Phone calls are received from patients who are discharged from the organisation. The hospital is encouraged to measure and evaluate the reasons for these calls back to the hospital to ensure that the discharge process is effective and opportunities for improvement are gained.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Blood and blood product policies and procedures are available at NCPH.

These are well supported by a Blood and Blood Working Party who report to the Infection Control Committee, Quality Management Committee, Clinical Consultative Committee and Leadership and Management Committee.

All Clinical staff are educated utilising the Blood Safe eLearning platform.

This is a mandatory training component of clinical staff contracts of employment. Ninety-four percent (94%) of staff have undertaken this training.

Blood and blood products are stored securely in a blood fridge within the perioperative area with security access. Assigned blood and emergency blood is logged appropriately.

Blood prescriptions are in place with 100% of patients receiving an accurate prescription along with consent prior to transfusion.

Blood incidents reporting occurs via normal incident reporting via RiskMan. The contracted pathology provider is made aware of all incidents and the outcome of blood pack testing following patient incident is communicated to the prescriber, patient and staff. Adverse reactions are the most common blood related incident however rare.

Blood and Blood Product Transport and Receipting is audited for compliance and this has resulted with industry guidelines being adhered.

Documenting patient information

A comprehensive patient history is documented prior to all transfusions (including transfusion history).

Blood transfusion audits are undertaken to ensure the accuracy of the prescription and products ordered match actual transfused packs.

Observations pre/post blood/product transfusions are industry accepted. There has been x2 massive transfusion related incidents and x2 blood wastage incidents within the previous two years. Both categories of incidents provided shared learning for all staff and the wider cluster group to further improve patient safety and decrease blood waste and related costs.

The shared learning platform Healthscope wide is a beneficial and effective method in ensuring all incidents are reviewed and action plans to minimise risks are adopted.

Managing blood and blood product safety

A monthly blood bank products report is produced by the pathology provider and presents units requested, units transfused and wastage.

Wastage of blood and blood products is monitored by the Blood and Blood Products Working Party at NCPH.

Transfusion cluster meetings discuss blood usage and wastage in an effort to mitigate waste and ensure compliance to transfusion policies. There is also local networking with the Canberra Hospital.

Communicating with patients and carers

A “General Guide to Blood Transfusion” information pamphlet is provided to all patients undergoing blood transfusion. It contains information on risks, consenting, alternatives and concerns.

The Blood and Blood Product Prescription and checklist also is shared with the patient where the Medical Officer is consenting the patient for transfusion.

Information regarding blood transfusion is available in the languages that meet the organisation’s demographic, and interpreters are available should patients not understand blood transfusion treatment orders.

‘Blood Matters’ Fact Sheets are a readily available consumer resource and are regularly reviewed by the consumer consultant.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Policies, procedures and protocols consistent with best practice guidelines are available to staff at National Capital Private Hospital (NCPH). The Pressure Injury Prevention Working Party and is responsible for overseeing pressure injuries and for managing pressure injuries. The results of audits and trends for pressure injuries are presented at the Quality Committee.

A number of quality activities are undertaken in relation to pressure injury management and prevention. These included the review of equipment into a centralised database to ensure staff were aware of available to achieve the best possible outcomes for patients at NCPH. The operating theatre also developed a pressure injury assessment on one sheet specifically for patients in the operating theatre for which they are to be congratulated.

The Healthscope Skin Integrity Assessment and Pressure Injury screening tool was developed to provide a best practice screening tool for patients on admission. The patient risk assessment tool is effectively used to develop a patient management plan for those patients at high risk in collaboration with the patient. Skin assessment, skin tears and wound product modules are available through eLearning.

Incidences of pressure injuries are reported through RiskMan. The system has also included the capability for staging pressure injuries.

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

Pressure injury prevention day was celebrated during the survey and a display of information, quizzes and prizes were provided.

Preventing pressure injuries

Established strategies based on best practice guidelines for the prevention and management of pressure injuries was clearly evident to the survey team. Education and training on pressure injury prevention and management for clinical staff is available.

Patients are routinely screened for pressure injuries and the potential for developing pressure injuries. Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines.

An agreed screening tools based on the tool are used for the screening of all patients which are accessible to clinicians. Education is provided to staff on the importance of skin integrity such as environmental factors and the personal factors related to the patient such as nutritional status, skin temperature, age and the presence of chronic disease. The Lessons Learnt learning package has been distributed to all relevant clinical staff.

It is evident comprehensive skin inspections are carried out on admission and regularly throughout the inpatient stay. The assessment developed for the operating theatre was particularly impressive with all pressure points being documented and assessed hourly. Interventions to minimise pressure injuries in the operating theatre are well documented. The assessment has been presented at forums and requests have been received from other facilities to use the assessment.

Managing pressure injuries

Audits to monitor the incidence of pressure injury regularly occur, management plans are evidence based and consistent with national guidelines. Staff have access to the Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury. Staff have access to a comprehensive policy and wound assessment chart which has a documented pain scale.

A range of pressure relieving devices is available for clinical areas including the operating suite

Communicating with patients and carers

Patients and their carers have opportunities to discuss pressure injuries with clinicians on admission and during the episode of care. Patients and carers are also involved in the development of the patient care plan and are able to indicate in the high-risk plan that they have been involved in the formulation of the planning process. Information on pressure injuries is available to patients in all clinical areas in the patient directory. These resources have been reviewed by consumers.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

Accountability and responsibility for the organisation's response system is well known to staff. A Working Party with specific terms of reference undertakes the operational/ practical aspects of the response system. The Clinical Consultative Committee, the ICU Committee and MAC all receive comprehensive reports regarding the system, in place, outcomes and the intended improvements. Escalation of care education and triggering a response to a deteriorating patient is undertaken at orientation and annually as part of the education required by all staff.

The Observation Chart which was implemented in April 2017 follows the 'Between the Flags' methodology and is generic across all Healthscope sites.

Observation Charts are audited for compliance, particularly to ensure that MET calls correspond to observations and or clinical record variances.

A suggestion has been made to increase the audit sample size of 50 Observation Chart audits per annum to a more realistic percentage of patient separations.

All deaths are reviewed locally by the NUM, DON and reported via the Mortality and Morbidity reporting to the MAC. Staff believe that Shared Learnings (Healthscope-wide) have assisted in evaluating the system of escalating care.

The staff of NCPH are mature in their knowledge of MET Call and the system in place to ensure patient safety.

Recognising clinical deterioration and escalating care

A suggestion has been made to evaluate the adopted Observation Chart at NCPH following its implementation to ensure it meets the needs of all clinical / medical staff.

Debriefing sessions are conducted following MET Calls to ensure staff are debriefed, opportunistically educated and supported. All staff are encouraged to call a MET if they are worried about the condition of a patient even if outside of the MET criteria.

MET criteria may be altered by the treating doctor in consultation with the nursing staff and following patient assessment. It may be helpful when evaluating the Observation Chart to measure how often the MET Guidelines are altered to ascertain whether the Chart is meeting the needs of the clinical profiles cared for at NCPH. The surveyors believe that measuring the times and episodes that the MET criteria has been overridden with alternate parameters could be reviewed and evaluated to ensure the parameters which have been endorsed are still meeting the case mix and cohort of the hospital.

Visual cues in all patient rooms and waiting areas are available for patients/carers to call a MET Call if they feel their or their loved ones condition is deteriorating. There has been the successful implementation of this system with two calls in the past quarter being made by carers.

Staff participate in MET 'Scenarios' which assist in ensuring that roles and responsibilities are known and practised to ensure staff responsibilities are defined.

Responding to clinical deterioration

Criteria for the activation of a MET Call are described within policy and procedures and a legend is found on the observation chart.

All MET calls are evaluated and reason / outcomes of calls are analysed.

Basic Life Support is undertaken by all staff - 92% of staff have completed mandatory training annually. The organisation is encouraged to ensure that 100% of all eligible staff inclusive of salaried medical officers have undertaken this training.

Advanced Life Support (ALS) staff are rostered for all shifts. The ICU Registrars/Physicians and hospital's RMO are all proficient in ALS.

Level 3 ICU requirements require transfer to the Canberra Hospital where agreements exist for these purposes.

The surveyors have noted that the Recovery Patient Observation Chart has not been converted to a graphical chart utilising the agreed criteria triggering a response for clinical deterioration. The organisation has assured the surveyors that a Healthscope approved Recovery Graphical Observation Chart is in the process of being rolled out.

Staff knowledge and satisfaction regarding the MET Call system in place is measured for effectiveness, with 92% of staff stating they have confidence in initiating calling a MET Call. This could be further evaluated following the feedback provided to ensure the process in place continues to meet the needs of the staff and the organisation.

Communicating with patients and carers

Advanced Care Directives (ACD) are encouraged to be available for hospital admissions. If patients do not have these, resource packs are available to assist with this process.

Two staff have undertaken ACD Practitioner training to support this initiative.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

The clinical work support staff are trained and proficient in basic life support.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Effective systems have been developed and implemented to support the prevention of falls and harm from falls at NCPH. Comprehensive referenced evidence-based policies and procedures were available. A multidisciplinary falls prevention working party is well established and provides effective oversight for falls. The working party reports to the Leadership and Management Committee who is responsible for the management of Falls at NCPH, it was evident that staff were extremely passionate regarding appropriate measures being in place to prevent falls and harm from falls. The committee monitors patient falls and develops strategies to prevent patients from falling. The results of investigations and trends are escalated to the Executive and the Medical Advisory Committee.

There is a robust system for reporting falls and related incidents through RiskMan and investigating them appropriately. Incidents relating to falls are reported to the Senior Nurse Team. Serious falls are reported the Leadership and Management Committee and the Executive Committee. Serious injuries are report to Healthscope and investigated via a root cause analysis.

Falls data is collated and presented to Healthscope Corporate quarterly and reviewed at the Falls Cluster meeting. This includes data on where the patients fell, when, their length of stay at the time of the fall, diagnosis and number of falls for each faller. This is compiled into a report that is tabled at the Falls Prevention Working Party and the Leadership and Management Committee.

Screening and assessing risks of falls and harm from falling

A number of quality activities are undertaken in relation to falls prevention and minimisation of patient harm. Evidence was seen that equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls. Sensor mats and grip socks have been implemented to minimise the risk of falling for high risk patients. Medication reviews, discharge planning and home assessments are undertaken as part as the comprehensive assessment and ongoing review.

Patients are screened for falls risk on admission including day procedure patients using the Falls Risk Assessment and Management Tool (FRAMT) and daily throughout their inpatient stay.

NCPH conducts compliance audits at least annually for falls documentation, it was observed that a falls history was conducted in the majority of patients, the falls risk score is documented.

All patients who are screened as high risk have a risk plan conducted with interventions noted on the form.

Preventing falls and harm from falling

Established falls prevention strategies were clearly evident to the survey team. Patients identified of being at risk of falling are appropriately identified and strategies for prevention implemented. Review of falls prevention strategies is embedded as being conducted daily. Multi-factorial falls prevention plans based on the individual patient's needs are developed and implemented.

Individualised Falls Actions Plans are developed in consultation with the patient or carer for those persons screened as high risk. Documentation indicates the patient or carer has been involved in the formulation of the plan included in the clinical record.

The use of equipment to prevent falls or minimise harm from falls is apparent. There is appropriate signage at the bed side to alert staff to the patient's potential for falling is used in clinical areas.

Communicating with patients and carers

Falls Prevention information has been developed in consultation with consumers, using their feedback to ensure the use of appropriate language and terminology. Information on falls prevention is available in all clinical areas and in the patient directory as well as individual education.

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 : National Capital Private Hospital, The
Orgcode : 820001

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : National Capital Private Hospital, The
Orgcode : 820001

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	SM	SM

	unexpected deterioration in health status		
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	SM	SM

	reported complaints		
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	SM	SM

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM

4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

	treatment or investigation is regularly monitored		
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are	SM	SM

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

Documenting patient information

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

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system	SM	SM

	• communication about clinical deterioration		
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

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

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Recommendations from Current Survey

Not applicable.

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Recommendations from Previous Survey

Not available.

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Combined

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

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

Surveyor - NSQHSS V01

Core

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

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

Developmental

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

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

NSQHSS Survey

Organisation : National Capital Private Hospital, The
Orgcode : 820001

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**