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

Prince of Wales Private Hospital

Randwick, NSW

Organisation Code: 12 00 01

Survey Date: 26-28 July 2016

ACHS Accreditation Status: **ACCREDITED**

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About The Australian Council on Healthcare Standards

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

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

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

- 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 Action Ratings Summary Report
3 Summary of Recommendations from Current Survey
4 Recommendations from Previous Survey
5 Standard Ratings Summary Report

1 Survey Team Summary Report

Consists of the following:

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

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.
The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

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

Action Recommendations

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

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

- 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

High Priority Recommendations (HPR) -

A High Priority Recommendation (HPR) is given to an organisation when:

- consumer / patient care is compromised and / or
- the safety of consumers / patients and / or staff is jeopardised.

Surveyors complete a risk assessment to validate their decision to allocate a HPR, which should be addressed by the organisation in the shortest time possible.

2 Actions Ratings Summary Report

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

3 Summary of Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.
Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the survey team regarding progress in relation to those recommendations are also recorded.
The action numbering relates to the month and year of survey and the action number. For example, recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1

5 Standards Ratings Summary Report

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

Organisation : Prince of Wales Private Hospital
Orgcode : 120001

Survey Report

Survey Overview

Prince of Wales Private Hospital (PoWPH) is a very busy private hospital with a predominantly elective surgical casemix co-located on a large campus with several other major hospitals. Although the licence identifies community health and sub-acute services in addition to acute, only acute services are provided and were thus surveyed as an NSQHSS Organisation Wide Survey. A comprehensive self-assessment was provided and surveyors visited all clinical areas, met with PoWPH executives and numerous clinical and non-clinical staff. Surveyors also met with several visiting medical officers who were members of the Medical Advisory Committee. Surveyors were provided with access to policies, procedures and other relevant documents.

Surveyors noted severe space constraints, and were informed of plans to rebuild and extend the facility, complicated by the fact that there are multiple major hospital campus partners who would be impacted by any future expansion. Consequently, planning has not yet progressed significantly. Nevertheless, PoWPH has multiple systems in place to effectively manage patient throughput and consumer expectations, within an embedded culture of quality and safety.

The organisation's risk management and quality frameworks are robust and the attention to quality and safety is much in evidence. PoWPH further understands the importance of audit and evaluation which have led to ongoing quality improvements across the ten National Safety and Quality Health Service (NSQHS) Standards.

Surveyors noted that staff were uniformly very proud of their organisation and have numerous opportunities for education, training and professional development.

The single recommendation from the previous survey was reviewed and closed, with four new recommendations being made and several suggestions. Work has been steady in improving processes associated with the ten National Standards.

Three actions have been rated Met with Merit (MM) having met the rigorous requirements to do so.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The governance framework at PoWPH is comprehensive. Actively supported by the parent corporation, the General Manager and the senior management team lead a strong culture of patient quality and safety, with rigorous systems of control, and an effective evaluation structure. Comprehensive oversighting of policies and procedures supports organisation-wide compliance and underpins sustainability. Examples were provided where patient safety and quality of care considerations were taken into account in business decision-making, including the introduction of an electronic blood tracking system. Comprehensive reporting to the highest level of governance occurs in regard to safety and quality indicators, and includes explanatory commentary. A clearly defined process is in place to produce data that is robust, timely and well-monitored.

Education of new employees and ongoing staff in regard to quality and safety is thorough. The well evaluated orientation/education program, presented via a range of novel methods, has demonstrated high levels of acceptability from staff and an embedded culture of quality and safety. An excellent example of how this has been achieved is through the National Standards Passport initiative. Because every staff member in the organisation could articulate their delegated safety and quality roles and responsibilities, and are very well supported to understand these roles (in particular in regard to the National Standards) as determined by a comprehensive evaluation program, Met with Merit ratings were achieved in Actions 1.3.1 and 1.3.2. It was noted at survey however that such consistency did not always extend to the agency workforce and a recommendation has been made to ensure that the locum/agency workforce has the necessary information, training and orientation to the workplace to fulfil their safety and quality roles. PoWPH's risk and quality management systems are well established and evaluated by the organisation and the corporate office annually. The Risk Register is a dynamic document, regularly reviewed. At survey all staff were aware of the risk management system, and were able to identify the key risks in their areas. The quality management system, overseen by the Quality Manager, is similarly well embedded in the organisation and able to be articulated by staff.

Clinical practice

There is a comprehensive policy on Clinical Pathways which has been recently reviewed. The Clinical Pathways have undergone changes and are now called Clinical Guidelines in some departments to encourage improved documentation rather than simply the ticking of boxes. Care plans have been extended to all areas and tailored to meet the needs in those domains. At risk patients are identified and effective systems to escalate care are in place.

Significant improvement in patient documentation has been made since the last survey which had identified deficiencies in this area. A working party was convened and the SOAP (Simple Object Access Protocol) model for documentation was chosen as this is consistent with what is used in Sydney Emergency Departments (EDs) and will also be compatible with an electronic health record (when this is introduced). A Documentation Specialist has been employed on a four-month trial to improve compliance and it is anticipated that this will become a permanent role. Education sessions have been rolled out to improve compliance with the new documentation format and recent audit of progress notes shows improvement.

The development of an electronic record for Healthscope hospitals is in progress. All new clinical record paper forms are considered by the clinical cluster of Healthscope to ensure they will be compatible with an electronic health record.

Performance and skills management

There is a very robust system for credentialing and definition of scope of practice for medical staff. Audits show 100% compliance. Department heads are informed of newly credentialed doctors and Visiting Medical Officers (VMOs) who are no longer active in the hospital do not have their credentialing renewed.

The electronic patient management system (WebPas) in theatre ensures doctors are working within their defined scope of practice. This has been verified by audit.

Registrars from the public hospital who work as Fellows are credentialed by their public hospital employer and this credentialing is mutually recognised by PoWPH. This also applies to emergency teams which come in response to a code blue from the Sydney Children's Hospital and The Royal Hospital for Women. Appropriate supervision of Career Medical Officers (CMOs) and trainees from the public hospital was evident.

There is active involvement of senior respected VMOs in performance management of their peers.

Regular performance review in nursing is undertaken at three months from first employment and yearly after that. It was noted that nursing staff turnover is only 8%.

There was ample evidence of ongoing safety and quality education; staff interviewed on the wards were cognisant of the National Standards and their application.

Surveys of the employees show a high level of satisfaction especially with the level of safety and quality in the organisation.

Incident and complaints management

The hospital uses RiskMan to record incidents and this is part of the Key Performance Indicator (KPI) reporting for Healthscpope. The definition of sentinel events is broad and in line with Healthscope Policy and Indemnity arrangements and all staff are trained and encouraged to report incidents.

All incidents are reviewed at an appropriate level and there is a documented reporting structure. Healthscope shares learning through incidents throughout all their hospitals via The Clinical Cluster reporting framework.

An open disclosure program is in place and there was evidence of staff training in this area.

All incidents are reported to the highest level of the organisation and personal contact when dealing with patient complaints is always undertaken.

Patient rights and engagement

There is an organisation charter of Patient Rights and Responsibilities which is freely available throughout the hospital and provided in the patient information pack on admission. Interpreters are available 24/7. Patient Care plans are developed for every patient and while there has been some improvement in compliance with the patient signature on the care plan, better results are targeted.

Compliance with consent documentation is very high. The generic consent form for Healthscope is to be introduced to PoWPH in the next six months.

The patient records are available at the point of care. Secure access to electronic results ensures confidentiality.

Patient satisfaction surveys are available and patient satisfaction overall at PowPH is above the Healthscope KPI.

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	MM
1.3.2	SM	MM
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

Action 1.3.1 Core

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

Surveyor Comment:

The organisation set out to improve workforce awareness of their designated safety and quality roles and responsibilities for all staff. Multiple strategies, including implementation of the very novel and successful National Standards Passport program, were employed to educate and monitor outcomes. One hundred percent (100%) of staff were found to understand their roles and responsibilities in regard to quality and safety. This was tested by surveyors and found to reflect audit outcomes. The program is ongoing (thus sustainable) and covered the entire relevant workforce. Surveyors agreed that all criteria for Met with Merit ratings were achieved.

Surveyor's Recommendation:

No recommendation

Action 1.3.2 Core

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

Surveyor Comment:

The organisation has improved support of individuals with delegated responsibilities to meet the requirements of the National Standards through the development and implementation of a comprehensive support program. This includes extensive education, competency assessments and mentoring. The National Standards Passport program was an excellent example of how this was achieved. Evaluation has demonstrated excellent understanding of delegated roles and responsibilities, confirmed at survey by surveyors. Surveyors were unanimous in agreeing that all criteria for Met with Merit rating were achieved.

Surveyor's Recommendation:

No recommendation

Action 1.4.3 Developmental

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

Surveyor Comment:

A comprehensive orientation program for locum and agency staff in regard to their safety and quality roles and responsibilities is in place. However, on speaking with a number of agency staff working in the organisation during survey, it was apparent that there was inconsistency in their knowledge of this with some agency workforce nurses being unable to articulate their roles and responsibilities.

Surveyor's Recommendation:

The organisation take the necessary steps to ensure that the locum and agency workforce has the necessary information, training and orientation to fulfil their safety and quality roles and responsibilities.

Risk Level: Low

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

NSQHSS Survey

Organisation : Prince of Wales Private Hospital
Orgcode : 120001

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

There are two key committees at the highest level of governance, being the Management Committee and the Medical Advisory Committee. Neither of these committees have consumers included among their membership. Three consumer representatives, all of whom were recruited following their patient experience (and two of whom are new to their role) participate on the Patient Care Review Committee (PCR), the Obstetric Committee and/or the Environmental Management and Sustainability Committee. In Action 2.1.1 a suggestion is made in relation to enhancing the role of consumers in the governance of the organisation.

The low number of consumers (three at the time of survey) limits the opportunity for consumers to be involved in strategic or operational planning, or educational and service review and evaluation activities. An intention to establish a Consumer Advisory Group (or similar) was stated during survey, and the draft terms of reference for such a group were shared with surveyors. Among the membership it was noted that senior staff take up the majority of positions on the committee, leaving limited representation by consumers.

The three consumers reported receiving an orientation booklet but no formal training has been provided/received prior to them taking on/or during their role as consumers. Accordingly, Action 2.3.1 has been rated as Not Met and a recommendation has been made**.** Each of the consumers reported that they have been able to access information to assist them in their roles, for example, a list of frequently used acronyms and their meanings has been provided to aid their understanding of conversations and data from reports when in committee. None of the consumers reported having had a Police Check, or a Working with Children Check, in preparation for their roles. This issue was further queried during survey and it was reported by national office representatives that it is not Healthscope policy to require either checks for consumers at this time. Surveyors noted that this position is not in-step with such requirements in other health services nationally.

The organisation applies the over-arching (Healthscope) consumer related policies on gaining consumer feedback. Accordingly, the organisation is included in the national program of information sharing and gaining feedback. Staff reported the regular application of an informal, verbal process to gather feedback and report the feedback to senior staff and each bed space includes a questionnaire for patient feedback.

While opportunities may be somewhat limited, there are nevertheless processes in place to invite consumer feedback on information drafted for patients and their families and/or carers. Consumers reported an experience where significant time and effort was put in to commenting on a draft document, only to have their comments disregarded. Nevertheless, the three consumers viewed this role as being very important to the information for use by future patients and their families/carers.

Surveyors noted that signage and way-finding information for patients and their visitors is limited across the site. On further discussion with senior staff it was revealed that the foyer and wider site is ‘owned’ by the public hospital / NSW Government and that this ownership limits the extent to which facility-relevant information is able to be made available to patients using the hospital. Surveyors agreed this is not an ideal basis for building effective partnerships with consumers using the facility.

Consumer partnership in designing care

Over 95% of the population accessing care are white, middle class Caucasians and this rate has remained static over many years. A small proportion of this population are considered 'Very Important Guests' and their care is managed accordingly. Consumers reported limited involvement in designing care. One of the three consumers regularly visits and speaks with patients and their families and/or carers about the care they have received, any concerns they may have, and any suggestions they have for improvements, if the patient's clinical condition warrants.

Staff access training on patient-centred care and it is an organisational requirement that this training is repeated annually. Whilst a consumer has been involved in the new staff orientation program since 2013 and consumers are involved in training the clinical workforce through education conference attendance, in Action 2.6.2 a suggestion is made regarding making consumer participation more meaningful for consumers and staff**.** It was reported that the special focus evenings that are held periodically and to which staff are invited for example, 'colo-rectal surgery and care', include consumer representatives.

Consumer partnership in service measurement and evaluation

Consumer involvement in the review and analysis of local data is limited. However, for the wider community the organisation provides service measurement and evaluation data to the Healthscope corporate office for uploading to the Healthscope public access website My Healthscope. Responses to the quarterly patient impressions survey are reported to the local management team. Surveyors did note from discussions during survey with clinical and administrative staff, (including the catering and cleaning staff) that local staff are using a range of mechanisms to gauge service satisfaction, and use this information to devise service improvement activities across the organisation.

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	NM
2.4.1	SM	SM
2.4.2	SM	SM

Action 2.1.1 Developmental

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

Surveyor Comment:

Consumers are involved in the governance of POWP by their attendance on a range of senior committees and in the wider sense through participation on several Healthscope corporate committees which assist hospitals in the group on relevant clinical and strategic matters. It is suggested however the organisation reviews its current processes so that consumers feel that their contributions are valued and useful.

Surveyor's Recommendation:

No recommendation

Action 2.3.1 Developmental

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

Surveyor Comment:

A booklet orienting consumers to the organisation is provided. In the absence of a formal/recognised training program for consumers to enable them to fulfil their role, training is both informal and ad hoc.

Surveyor's Recommendation:

When consumers and/or carers join the organisation in formal consumer roles, ensure that there is a training program to prepare them for and maintain their roles over time, in relation to governance, planning and safety and quality decision making.

Risk Level: Low

Consumer partnership in designing care

Ratings

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

Action 2.6.2 Developmental

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

Surveyor Comment:

Consumers are routinely involved in the orientation program and training the clinical workforce through attendance at the organisation's education conference. The consumers themselves however did not feel that their contribution was optimal to the organisation in this regard and a suggestion is made that POWP reviews its current program to make consumer participation more meaningful for consumers and staff.

Surveyor's Recommendation:

No recommendation

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

An excellent governance system is in place at PoWPH in regard to preventing and controlling healthcare associated infections, with ongoing improvement noted over time. A collaborative approach between the parent corporation, the organisation's expert external providers of infection control (IC) services and PoWPH itself, ensures robust, evidence-based information and support is available to staff at all times. A risk managed approach to the IC framework is very evident in relation to policies, procedures and protocols, which are contemporaneous, comprehensive and reflective of PoWPH's unique situation (such as close proximity to the international airport). Responses to emerging risks such as Ebola Virus (in 2014) and Zika Virus in 2015 have been excellent, being both timely and thorough. The ongoing improvement in the policy and procedure system, which is available to all staff in the organisation, and whose effectiveness is evaluated regularly has led to this action (3.1.1) being assessed as Met with Merit by surveyors.

An effective IC cluster at corporate level, informed by appropriate committees at local level results in the IC framework being regularly reviewed (and improved as required) at the highest level of governance. Quality improvement is ongoing and several initiatives to maintain/strengthen organisational response to infection prevention and control were evident, evaluated regularly in line with the infection control plan. A risk assessment program is in place and conducted at least annually in all wards and departments. Surveillance is thorough, and acquired infection rates are very low.

Infection prevention and control strategies

Infection prevention and control is a high priority for the organisation. The Hand Hygiene Program in particular demonstrates organisational commitment, with rates above the national benchmark at 87% across the board. A great deal of work has been put into the workforce immunisation program and all new employees are now required to provide immune status for a defined suite of infectious diseases before commencement which is then included in a staff database. Infection Control staff are also diligently working through the existing workforce to strengthen record keeping in this regard. Close relationships exist between Infection Control staff and OH&S staff to maintain workplace safety as regards exposures to blood and body fluids and other relevant occupational health issues. Invasive device management is thorough and compliance rates are high, as determined through audit and observation, in keeping with the hospital's policy.

High compliance with aseptic technique training is noted, being consistently above 85% of the relevant workforce and higher in high risk areas. A comprehensive program is in place to identify staff requiring training; to provide appropriate training tools, and to audit compliance with training packages and observation of correct technique. The organisation fully meets the requirements under transitional arrangements for action 3.10.1.

Managing patients with infections or colonisations

Guidelines in relation to standard precautions and transmission-based precautions are in place. A risk analysis is undertaken to consider the need for transmission based precautions for patients including accommodation based on mode of transmission; environmental controls through air flow; and transportation within the facility; cleaning procedures and equipment requirements.

Appropriate communication about patients' infection status is in place through an effective electronic alert system and close monitoring by the Infection Control nurse. Appropriate personal protective equipment (PPE) was observed to be in use. Effective management is supported by numerous single rooms and a largely elective case mix although the very busy environment necessitates constant vigilance.

Antimicrobial stewardship

The Antimicrobial Stewardship (AMS) Committee commenced in May 2016.Despite this late start with a specific committee The PoWPH has been complying with the rest of this standard principally through the work of the pharmacy and the Medical Advisory committee and with the assistance of an Infectious Diseases physician.

The new AMS Committee has only met once and is in the process of determining it Terms of Reference. Review of the terms of reference in other Healthscope hospitals is recommended as part of this process.

The clinical workforce has access to the current endorsed therapeutic guidelines through a variety of means and monitoring shows excellent compliance. Education around a recent change in a therapeutic guideline for antimicrobial prophylaxis in joint replacement was demonstrated.

Monitoring of the use of antimicrobials is undertaken by the pharmacy and feedback to the clinicians is through the Medical Advisory Committee.

With the formation of the AMS committee, governance of the use of antimicrobials will now be formalised.

Cleaning, disinfection and sterilisation

Surveyors were impressed by the cleanliness and maintenance of this very busy organisation. Despite corridors full of equipment due to severe storage limitations, a strict cleaning program, which is frequently audited, demonstrates very high quality assurance. Surveyors noted a range of initiatives to ensure the organisation is maintained in optimal condition, including extensive education opportunities, and clear work instructions, supported by a range of policies. Plans to introduce visual cleaning instructions alongside written information to assist staff for whom English is a second language were noted and the survey team look forward to seeing this activity come to fruition in coming months. Cleaning products are appropriately managed and material safety data sheets are readily available.

It was noted that the Central Sterile Supply Department (CSSD), which has been under stress due to space and work flow constraints (with some outdated equipment), will undergo refurbishment at the end of the year to eliminate/minimise associated risks. Despite this, the cleaning, disinfection and sterilisation of reusable items was noted to be in accordance with Australian Standard 4187 both in CSSD and the Day of Surgery Service, which has a very busy endoscopy service. An AS 4187 - 2014 plan has been developed, and implementation already commenced. The corporation has committed to the necessary capital expenditure to meet the new requirements of the Standard which will be rolled out across its hospitals in coming years. A tracking system is in place and instruments and trays are able to be traced to individual patients. As neurosurgery is conducted at PoWPH, rigorous processes are in place to minimise the risks associated with CJD, including single use of instruments in known cases. Integrity of sterilisation is rigorously monitored. All staff involved in decontamination, disinfection and sterilisation are appropriately trained. The availability of a specific CSSD educator was seen as a very unusual – and welcome resource - for staff.

Communicating with patients and carers

Information on the organisation's corporate and clinical infection risks is available to patients and carers at point of care and via the 'My Healthscope' website. Patients, carers and visitors are able to access an extensive range of information relating to infection prevention and management, including hand hygiene. Surveyors noted children using hand hygiene products throughout the hospital. Feedback regarding the effectiveness of information material is sought from patients through patient satisfaction surveys.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	MM
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

Action 3.1.1 Core

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

Surveyor Comment:

Policies and procedures related to infection control are outstanding. The system to ensure they are comprehensively risk-rated and relevant is continually improved; for example, the hospital's proximity to Sydney International Airport warrants special attention in relation to exotic viruses being transported into the country. All relevant staff, including new employees and agency staff, are regularly educated in how to access policies; changes in policy, and how to seek additional information when required. Support in regard to this latter point was timely and high quality. All surveyors acknowledge that the criteria for a Met with Merit rating have been achieved.

Surveyor's Recommendation:

No recommendation

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:

Almost 100% relevant clinical staff are trained in aseptic technique, thereby fully meeting the requirements for transitional arrangements 2016.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Governance of medication safety at PoWPH is defined by the Healthscope Medication Safety Cluster. The PoWPH has a Pharmacy Committee that reports to the Patient Care Review committee and then onto the Medical Advisory Committee. The terms of reference are reviewed annually.

Corporate medication safety policies are available to all staff via the intranet and there is evidence of regular education on medication safety.

Medication management is regularly assessed using a variety of tools including the Medication safety self-assessment for Australian Hospitals as well as using Healthscope KPI for medication incidents. PoWPH is well within the Healthscope benchmark.

A reduction in medication incidents has been achieved with the purchase and use of the Alaris guardrail Smart pump throughout the hospital for every infusion.

The introduction of the paediatric dose calculation checklist is a significant initiative and has reduced errors in paediatric medication dosing. There is an e learning tool for drug calculation available and CMOs are tested annually.

The pharmacy holds a catalogue of all credentialled doctors working at PoWPH and their prescriber number, and all prescriptions are checked to this catalogue.

All patient and non-patient medication incidents are reported in RiskMan. Overall medication incidents in PowPH are below the Healthscope benchmark.

Documentation of patient information

All patient medication is documented on admission and any patient with four (4) or more high risk medications will be seen by a pharmacist.

The medication management plan and the National Inpatient medication chart are at the patient bedside and audit shows excellent compliance with documentation. Known allergies are written on the alert page at the front of the case notes and a red alert arm band is placed on the patient.

All adverse drug reactions are reported to the Therapeutic Goods Administration (TGA) by the pharmacist or PoWPH/Corporate management.

Medication management processes

Access to current drug information is available in multiple form both online and in hard copy in clinical areas and there is an on call pharmacist available.

Medications are secured appropriately including S4 and S8 drugs. The storage of temperature sensitive drugs is monitored and alarms are tested.

Compliance with appropriate disposal of unwanted medicines including cytotoxic drugs is audited.

Spill kits are available and practice drill on their use occurs six monthly.

Continuity of medication management

There is a range of relevant Healthscope policies in relation to medication management on patient discharge. Analysis of discharge medication information had shown reduced compliance and a discharge medication checklist has been implemented with improved results.

The onsite pharmacy provides monthly reports to the Senior Clinical Managers on the provision of a medication profile.

Communicating with patients and carers

Medication management plans are discussed with patients in accordance to the Healthscope policy and audit has shown a high level of patient satisfaction.

Increased participation of pharmacists has improved information and education for patients about their drugs on discharge, particularly high risk medications such as warfarin, and medications that have been prescribed following cardiac surgery.

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

There is an organisation-wide system for patient identification in place. The system relies on the use of four patient identifiers and is supported by a policy and agreed procedures for application in a range of settings, and is supported by regular audit activity. There is a Committee to oversight and report on the effectiveness of this system. The patient information booklet includes a section that is designed to allay any patient concern by informing them this process is routine. The section further explains why this is undertaken, and how and when a patient could expect patient identification to be checked.

The system includes the use of agreed (white and red) identification bands. Staff reported recent efforts to improve the type of identification bands used in the maternity section, and revealed an improved wearability of the new bands by newborns, following introduction of the new (softer) form of bands.

Processes to transfer care

Surveyors noted a consistent approach across a variety of settings to confirm a patient's identity when transferring responsibility for care. Again, the four patient identifiers form the basis of this activity.

Processes to match patients and their care

The organisation applies standardised processes to match patients to their intended procedure and where possible, patients are included in these processes. Standardised time-out procedures are applied in a number of settings. The processes are audited and recommendations for ongoing improvements are taken seriously and applied where and as appropriate. Clinical staff reported that the use of agency staff is less of an issue / risk than in previous times, as the application of this Standard in all health services means all staff are now embedding this checking process into their day-to-day practice.

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

The focus on improving the clinical handover process was evident at PoWPH. A working party is in place and has assisted in the development and implementation of a comprehensive framework, which includes policies and procedures, supporting tools and an audit program to monitor compliance. This information is readily available and staff were able to demonstrate to the survey team their ability to locate these policies and procedures. Handover audit outcomes demonstrate steady improvement across the board. A multidisciplinary approach was taken in the development of the handover framework. The 6 North Clinical Handover video was noted to be an excellent educative tool, with built in errors for detection by new staff. Attention has also been given to medical staff handover through the recent introduction of an ISBAR-based framework to guide handover and provide an evaluation mechanism.

Clinical handover processes

Clinical handover practices were observed in a range of settings including admission, transfer to Operating Theatre (OT), OT to Recovery ward and on discharge. Clinician to clinician and clinician to non-clinician handovers were also observed. On each occasion handover was thorough and compliant with policy and procedure, including the use of ISBAR principles. It was pleasing to note that attention to Nursing Discharge Summaries has seen compliance increase markedly over the past twelve months thereby improving clinical communication with external health professionals. The use of a wardsperson handover process was also seen as a positive step towards streamlining patient flow and minimising patient identification errors.

Regular audit and incident reviews have provided opportunities to improve handover practices, which have been diligently implemented as required. One area ripe for improvement was noted. Whilst the organisation has put a significant effort into internal clinical handover practices, there is still inconsistency in regard to patient transfers (which are many and frequent) between the multiple healthcare organisations which share the campus. A recommendation has therefore been made to strengthen clinical handover practices between providers under action 6.3.3.

Patient and carer involvement in clinical handover

It was pleasing to note the ease of communication between patients/ family members and staff at every observed clinical handover, indicating a well embedded process. Journey boards are similarly well used and appreciated by patients/carers.

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

Action 6.3.3 Core

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

Surveyor Comment:

Clinical handover between internal wards and departments was generally very well conducted. However, there was noted to be limited protocols in place, and therefore inconsistent practice handing over between the organisation and external partners, placing patients at potential risk.

Surveyor's Recommendation:

Increase the effectiveness of clinical handover between external partner organisations (and other external agencies) by developing, implementing and monitoring a system for effective clinical handover in these circumstances.

Risk Level: Low

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

Effective governance over blood and blood product use at PoWPH is evident and it was pleasing to note excellent relationships have now been established between campus partners who all participate in and contribute to the Randwick Campus Transfusion Committee. This collaborative approach, combined with outputs from the Healthscope Corporate Cluster relating to Blood Management has ensured effective policy and processes, congruent with those of the National Blood Authority, being in place.

Effective haemovigilance processes, including a range of audit tools are used to monitor appropriate usage, wastage, adverse events and near misses, both locally and at campus level. All parameters are appropriately minimal. A massive transfusion protocol has been implemented on several occasions with good clinical outcomes and ROTEM (rotational thromboelastometry) has recently been introduced in the Intensive Care Unit to rapidly measure blood coagulation.

The organisation has also recently invested in an electronic tracking system to assist in the safe and timely dispensing of blood and blood products.

The location of the campus Blood Bank, one floor below the PoWPH facilitates rapid access to blood in an emergency.

Documenting patient information

A blood transfusion prescribing checklist has been introduced and systems are in place to oversee that important documentation relating to transfusion history, indications for use and adequate observation is correctly and comprehensively recorded. It is likely that the recent Documentation Project will have assisted in this process. A range of audits are reported locally, at campus level and to the corporation to monitor the effectiveness of processes.

The pre-admission clinic consultation remains an important vehicle for obtaining adequate information regarding previous history as most patients attending PoWPH who will require a blood transfusion do so as elective patients.

The Patient Care Review Committee remains the body responsible for oversighting blood and blood management in regard to accuracy of documentation of patient information, the results of which are also provided to the campus Transfusion Committee and the Corporate entity.

Managing blood and blood product safety

Appropriate systems, consistent with national guidelines are in place in regard to receipt, storage, collection and transport of blood and blood products, including the recent introduction of an electronic tracking system to minimise risks associated with these elements. The Blood Fridge in the Operating Theatre is alarmed and monitored in accordance with policy.

As in the past, incidents are reported via the RiskMan Incident Reporting System and the corporate office includes blood incidents in required KPIs. Blood related incidents at PoWPH are negligible, resulting, in part, from a zero tolerance approach.

Extensive education is provided to staff in regard to blood and blood product management. All relevant staff, including employed medical officers (CMOs) are required to complete the Blood-Safe e-learning package. High levels of compliance are noted.

Wastage is minimal and effective systems are in place to recycle non-required blood to elsewhere on the campus prior to the expiry date.

Communicating with patients and carers

Educational material in plain language was noted to be available to patients and carers in regard to blood and blood products. Forms have been revised to include sections to record the provision of information to patients for audit purposes, and a specific Blood Transfusion consent form includes information to allow for informed consent.

In many cases however, a general surgical consent form is used instead of the specific form, and this generic form only contains a tick box relating to consent for blood transfusion. The use of this form does not indicate whether or not consent is informed; and it has been recorded at the Anaesthetics Committee meeting, that the specific tick box is not always checked, presenting a dilemma for anaesthetists should blood be required during surgery. A recommendation has been made to ensure that consent for blood transfusion is informed under action 7.11.1.

Feedback on suitability of printed material is included in the organisation’s patient feedback mechanisms, including the My Healthscope website.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

Action 7.11.1 Developmental

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

Surveyor Comment:

Two systems are in place to gain informed consent for transfusion of blood and blood products. One system uses a consent form which is specific for blood and blood products, and contains the necessary information or prompts. However, in many cases consent is obtained on a general procedural consent form using a tick box format. Sometimes the tick box has not been ticked. This has been a cause for concern for anaesthetists who may be reluctant to administer blood in the absence of informed consent (except in emergency situations). Even if the box is ticked it cannot be confirmed that consent has been informed in accordance with policy.

Surveyor's Recommendation:

Develop an audit schedule to identify whether or not informed consent is being obtained in regard to transfusion of blood and blood products and take steps, if required, to improve outcomes.

Risk Level: Low

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

There is a policy and associated procedures in place for the prevention and management of pressure injuries, and these are consistent with best practice. Screening tools are standardised and applied consistently. Audits are undertaken to measure compliance to the policy. Incidents are reported using the standardised incident reporting forms. There is an established committee-structure to oversight the management of this activity across the organisation. Regular incident and severity reports are provided to the Healthscope Central Office. Staff reported ease of access to equipment and devices for the prevention of pressure injuries. Data revealed a low rate of hospital-acquired pressure injury.

Preventing pressure injuries

Patients are screened on presentation and those at risk of a pressure injury are identified for ongoing care for injury prevention. The range, complexity and time involved in many of the surgical procedures that are undertaken requires a comprehensive skin check is undertaken routinely on many patients. Staff reported access to, and the use of, an extensive array of equipment in the theatre unit to assist in the prevention of pressure injuries on patients identified as being at risk.

Managing pressure injuries

There is a wound management system in place. This system is led by a trained nurse with specialised additional training and supported with a range of information and products for use.

Communicating with patients and carers

The Patient Information Booklet details information on the prevention and management of pressure injuries and there is a suite of other information also available and provided on an ‘as needed’ basis. While the numerator is small, recent audits reveal that patients and families and / or carers were involved in the development of management plans.

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

The clinical deterioration rapid response system is named Code Blue to align with the co-located public hospitals. The Patient Care Review Committee reviews all Morbidity/Mortality committee reviews and results from the various specialties, the clinical indicator data and sentinel events. Healthscope has comprehensive policies on clinical deterioration which include escalation of care, cardiac arrest in the operating room and for a Lower Uterine Segment Caesarian Section (LSCS) obstetric emergency.

Staff are encouraged to call a code blue when concerned about a patient even if a VMO is in attendance.

Recognising clinical deterioration and escalating care

In line with Healthscope policy observation charts consistent with the national consensus statement were introduced for adults in 2013. Audits indicate excellent compliance with documentation and escalation of care being activated according to the set parameters. Charts for special groups such as neonates, children and postnatal women have only been introduced recently (late last year) and are yet to undergo audit.

Responding to clinical deterioration

There are now Digital Enhanced Cordless Telecommunications (DECT) phones for the CMOs who are the first to be called to review a deteriorating patient. If there is no response by the CMO in 30 minutes a code blue call is activated. Rostering ensures that there is always at least one Advanced Life Support (ALS) trained person on the team. Contractual arrangements with the co-located Sydney Children's Hospital and the Royal Hospital for Women provide specialist emergency treatment for children and neonates if necessary, and the contact is made by DECT phone.

Basic Life Support (BLS) training is mandated for all staff. Compliance at a recent audit was at 95%. The organisation fully meets the requirements under transitional arrangements for action 9.6.1.

Communicating with patients and carers

There are policies relating to Advance Care Directives and End-of-Life Care and Decision making. If a patient has an Advance Care Directive this is documented on the patient alert sheet in the front of the case notes and is also entered into the electronic WebPas patient information as an alert.

Patients and their carers are informed of their right to escalate care on admission. The phone number and instructions, and how to escalate care, is printed on the patient journey board.

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

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

There is a policy and associated procedures in place for preventing falls and harm from falls, and these are consistent with best practice. Screening tools are standardised and applied consistently. Audits are undertaken to measure compliance to the policy. Incidents are reported using the standardised incident reporting forms. There is an established committee-structure to oversight the management of this activity across the organisation. Regular incident and severity reports are provided to the Healthscope Central Office. Staff reported ease of access to equipment and devices for the prevention of falls. Data revealed a low rate of falls and injury arising from falling.

Screening and assessing risks of falls and harm from falling

Patients are screened on presentation and those at risk of falling are identified for ongoing care for falls prevention. It is standard practice for patients receiving certain types of surgery, for example, orthopaedic surgery, to have a physiotherapist with them when getting out of bed for the first time post-surgery. Staff reported a recent incident and subsequent work undertaken to improve the management of falls risk in the paediatric ward. It was also reported that this work has not yet been endorsed for implementation by the Corporate Office of Healthscope and therefore has not yet been fully implemented.

Preventing falls and harm from falling

There is a systematic approach to managing falls risk, and an auditing process to inform the effectiveness of the approach taken. Staff are encouraged to make any further improvements, and supported to work with families / carers to include them and assist them to participate fully in the management planning process. The Clinical Handover procedure includes an identifiable section to discuss the falls management plan.

Communicating with patients and carers

The Patient Information Booklet details information on the prevention and management of falls and injury from falling, and there is a suite of other information also available and provided on an ‘as needed’ basis. While the numerator is small, recent audits reveal that patients and families and/or carers were involved in the development of falls management plans.

Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Prince of Wales Private Hospital
Orgcode : 120001

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	MM
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	MM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

Documenting patient information

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

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

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Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

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

Communicating with patients and carers

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

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Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM

10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

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Recommendations from Current Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.4
Action: 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

Surveyor's Recommendation:

The organisation take the necessary steps to ensure that the locum and agency workforce has the necessary information, training and orientation to fulfil their safety and quality roles and responsibilities.

Standard: Partnering with Consumers
Item: 2.3
Action: 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role

Surveyor's Recommendation:

When consumers and/or carers join the organisation in formal consumer roles, ensure that there is a training program to prepare them for and maintain their roles over time, in relation to governance, planning and safety and quality decision making.

Standard: Clinical Handover
Item: 6.3
Action: 6.3.3 Action is taken to increase the effectiveness of clinical handover

Surveyor's Recommendation:

Increase the effectiveness of clinical handover between external partner organisations (and other external agencies) by developing, implementing and monitoring a system for effective clinical handover in these circumstances.

Standard: Blood and Blood Products
Item: 7.11
Action: 7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation

Surveyor's Recommendation:

Develop an audit schedule to identify whether or not informed consent is being obtained in regard to transfusion of blood and blood products and take steps, if required, to improve outcomes.

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Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Clinical practice
Action: 1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care

Recommendation: NSQHSS Survey 0913.1.9.1

Recommendation:

Continue the strategies to improving the medical documentation in the patient's clinical record in conjunction with the Medical Advisory Committee.

Action:

Recommendation:

Continue the strategies to improving the medical documentation in the patient's clinical record in conjunction with the Medical Advisory Committee (MAC).

Action:

Prince of Wales Private Hospital response to the NSQHSS ACHS recommendation.
The recommendation was tabled for discussion at the February 2014 Medical Advisory Committee with no feedback on how the recommendation should be managed. The PoWPH Executive reviewed the ACHS recommendation and while supporting the intent chose to approach the issue from a multidisciplinary perspective that included VMO documentation.

2014
The Director of Nursing (DoN) and Quality Manager reviewed documentation throughout the patient journey and this highlighted an inconsistent process within PoWPH clinical departments. During the review process interventions were segregated into Day Only and Multi Day patients with standard accepted documentation for Nursing, Allied Health, Career Medical Officers (CMO) and Visiting Medical Officers (VMO) established within these two separate groups.
Medical record forms are made available within a PoWPH register, reviewed 3 yearly, meet Australian Standards and all new forms only implemented with authorisation of the Director of Nursing or General Manager. Healthscope generic medical record forms are increasingly superseding site-specific forms providing standardisation and compliance benchmarking opportunities. To promote contemporaneous documentation nursing staff accompany VMO's during ward rounds with a strong recommendation to document instructions and clinical outcomes within the progress notes. To facilitate compliance with discharge documentation, a pre-printed label was proposed for insertion in the progress notes at the time of discharge to ensure all medical record documentation was complete.

July 7th 2014
The DoN presented the outcomes from the review to the managers at the Senior Clinical Managers meeting. Feedback was requested on the findings and the proposed discharge documentation confirmation label prior to the August 4th 2014 meeting.

August 3rd 2014
The DoN presented the project findings and suggested strategies at the Patient Care Review Committee and were accepted, a consumer also sits on this committee.

August 4th 2014
No additional changes from Senior Clinical Managers Committee to proposed discharge label.

August 19th 2014
Final review of the proposed changes prior to implementation tabled at the MAC. The MAC reviewed the proposal with no consensus gained on the proposed actions requesting further refinement and to investigate a web based solution for VMO access to the medical discharge summary.

September 8th 2014
Further discussion between the Director of Nursing and General Manager with consideration for an ‘app’ to facilitate VMO completion of the discharge summary

October 10th 2014
DoN investigates the proposed 'app' for the medical discharge summary with Healthscope corporate IT.

Jan 2015
Executive collaboration with Healthscope Clinicals to include a Healthscope generic discharge summary with approval to proceed from the MAC and Patient Care Review Committee and a draft medical discharge summary developed with hard copy testing due October 2015. Testing of a mobile access portal was conducted during Jan 2015.

June 2015
Data over a two-year period from the PoWPH monthly nursing medical record documentation compliance audits was analysed and while there have been improvements further work is required with a decision for a new approach. The outcome data is being utilised to inform the objectives of a Documentation Working Party including but not limited to:

- Exploring the implementation of a nursing discharge reconciliation medical record form in partnership with the consumer – Complete September 2015
- Implementation of SOAP/SOAPIE documentation a problem-oriented technique whereby the nurse identifies and lists the patient’s health concerns. This would then be supported by the PoWPH ‘Write it Down’ minimum standards of documentation
- Analyse available clinical pathway data to review the continued use of clinical pathways or utilise care plans supported by clinical guidelines. 2016 decision supported by the Executive to make pathways obsolete following implementation of clinical care plans and guidelines other than in the critical care areas
- Develop a documentation competency - Complete
- Secure engagement from the clinical managers and provide evidence of good and bad documentation within their department - Complete

- Develop an education program for all staff - Complete with NSQHSS and Documentation Day 15th March 2016 with 179 participants and evaluated with >90% satisfaction. The education day included PoWPH consumer representative participation and support
- Comply with the implementation deadline of March 2016 - Complete
- March 2016 approval for a new Clinical Documentation Specialist position with education in clinical documentation and compliance with NSQHSS priorities, legislative and coding standards for both nursing, CMO's and VMOs.

Outcomes.

- Phase 1 of the Documentation Project is complete. Phase 2 will review compliance with documentation in the SOAP/SOAPIE format as well as monitoring compliance with risk assessment documentation and planning.
- VMO compliance with the medical discharge summary 26% 2013 increasing to 32% 2014 and 67% 2015
- The revised VMO discharge summary was tabled at the April 2016 MAC and approved for implementation and compliance being monitored within phase 2 of the Documentation Project.

Evidence.

- MAC minutes
- SCMC minutes
- Documentation Working Party Phase 1 report
- 2013 -2015 Medical record audit graphs for outcomes for VMO discharge summaries in specialty areas
- Clinical Documentation Specialist job description.

Completion Due by: June 2016

Responsibility: Executive

Organisation Completed: Yes

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

There has been significant progress in improving patient documentation. A working party was convened to focus on progress note documentation and various models were reviewed. The Subjective, Objective, Assessment and Plan (SOAP) was deemed the most appropriate to adopt as it is used in a number of Emergency Departments in the Sydney area and it is compatible with an electronic health record.

Clinical Pathways have been replaced with Clinical Guidelines which encourages structured documentation rather than just tick boxing and audits have shown this change has been successfully adopted.

A Documentation Specialist has been employed on a four-month trial with a view to a permanent position. Intensive education of staff with "Write it Down" lanyard card reminders has been introduced and an audit in June 2016 shows improvement in documentation in the progress notes in all areas.

The new VMO discharge summary has been implemented and audit shows improved compliance from 26% in 2013 to 67% in 2015. Further work by the MAC to improve compliance with documentation by the VMOs is continuing.

Organisation : Prince of Wales Private Hospital
Orgcode : 120001

Standards Rating Summary Report

Organisation - NSQHSS V01

Core

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

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

Developmental

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

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

Combined

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

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

NSQHSS Survey

Organisation : Prince of Wales Private Hospital
Orgcode : 120001

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	42	2	44
Standard 2	4	0	4
Standard 3	38	1	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	**206**	**3**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	1	10	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	**1**	**46**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	10	0	10
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	**46**	**0**	**46**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	1	14	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	**1**	**255**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	51	2	53	Met
Standard 2	14	0	14	Met
Standard 3	40	1	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	**252**	**3**	**255**	**Met**