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

Ringwood Private Hospital

Ringwood East, VIC

Organisation Code: 22 01 94

Survey Date: 7-9 March 2017

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Ringwood Private Hospital
Orgcode : 220194

Survey Report

Survey Overview

Ringwood Private Hospital (RPH) is a 75-bed facility which provides acute medical, surgical, oncology and palliative care services to the immediate community of Ringwood East and surrounding communities. The facility is the only private acute facility in the area offering a comprehensive on-site oncology service. It is owned and operated by Healthscope Ltd (HSP). RPH is part of the HSP Eastern Cluster (Melbourne) and has strong relationships with Knox Private, Bellbird, Private ad Victorian Rehabilitation Centre. HSP National team provides support to the RPH workforce through policies, guidelines and frameworks and opportunities to participate in benchmarking with facilities in the HSP Group.

This survey against the National Safety and Quality Health Service (NSQHS) Standards was undertaken between 7th and 9th March 2017 and included an on-site assessment by two surveyors.

The survey team was impressed with the progress made by the organisation in the implementation of the NSQHS and development of services since the previous survey in 2014. It is evident that the Executive and staff are continuing to strive for excellence in the standard of healthcare provided. A distinct focus is evident throughout the organisation on the engagement of the hospital's workforce to ensure safe and quality care is provided for consumers and in fostering partnerships with consumers and carers. An emphasis is being placed on integration with the other Eastern Cluster hospitals and increased flows of patients between facilities. Enhancement and improved integration of clinical models of cancer services have been associated with the establishment of a centralised cancer service, Ringwood Cancer Care, establishment of a Rapid Access Breast clinic, Lymphoedema Clinic and gym. Cancer support services continue to be offered to patients, families and carers in the Ringwood community and surrounding areas with a substantial increase in counselling services provided by the Cancer Support Nurse. The organisation reported that flows of medical patient from Knox Private Hospital have increased in the past twelve months and patients with higher acuity are being admitted to RPH.

All the previous recommendations have been satisfactorily addressed and are closed.

RPH has achieved the following Met with Merit ratings:
1.2.1 Core - Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance;
1.6.1 Core - An organisation-wide quality management system is used and regularly monitored;
1.6.2 Core - Actions are taken to maximise patient quality of care;
10.6.2 Core - The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment; and
10.6.3 Core - Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment.

All other Core and all the Developmental actions are assessed as Satisfactorily Met (SM). Core actions 3.10.1 and 9.6.1 are assessed as fully met.

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

Organisation : Ringwood Private Hospital
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STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Ringwood Private Hospital (RPH) has an integrated system of governance that manages patient safety and quality. This is supported with a clearly documented committee structure. The peak clinical quality and safety committees are the Quality Committee and the Patient Care Review Committee. Both meet regularly, have standing quality and safety agenda items and report to the Executive Committee. Evidence was available indicating the Medical Advisory Committee (MAC) and the Healthscope (HSP) National Safety and Quality Committee regularly receive reports on RPH safety and quality performance.

The system for management of policies/procedures and clinical guidelines is well-established at both corporate and local levels and shows evidence of version control, ongoing review and currency of information. HSP policies/procedures/ clinical guidelines are integrated into an electronic directory which is available on the HSP intranet (HINT) and the RPH L Drive, and are readily accessible by RPH end-users. A hard copy policy/procedure manual is maintained in the Executive Suite. Processes are well-established for ensuring legislative compliance and alerts when legislative changes occur and for communicating new and revised policy documents to the workforce. A system of checks and balances at Corporate and local levels is established to ensure legislative compliance. Compliance with policies occurs via a very comprehensive audit schedule and incident monitoring.

Consideration of patient safety and quality of care is evident in the RPH Strategic, Operational and Safety and Quality plans which link to the Corporate Strategic Plan.

RPH collects data on an extensive suite of safety and quality indicators (N=55) which incorporate the requirements of the NSQHS and risks identified in RiskMan, and Healthscope ‘never events’. An extensive suite of clinical indicators is also collected. Quarterly Safety and Quality reports are submitted to the Corporate clinical governance team, and performance is measured against targets, trended and benchmarked across HSP hospitals. Reports show all outliers which do not meet the specified performance targets and the hospital is required to submit action plans within a target timeframe of one week to address areas below target. RPH performance is monitored by the HSP National Safety and Quality Committee, the Executive Management Team, the Board, and by the various RPH Committees. Evidence provided showed in 2015 RPH had 27% KPIs below target and at June 2016 10% were below target, an improvement of 17%. The survey team agreed that there is substantial evidence of a consistent, well-established and sustained organisation-wide approach for regular reporting of safety and quality indicators and other safety and quality data by RPH and monitoring of performance, and has rated action 1.1.2 as Met with Merit (MM).

The RPH organisation chart clearly outlines reporting lines and responsibilities of staff. Position descriptions indicate workforce responsibilities for safety and quality. Information related to safety and quality responsibilities of the workforce is included in orientation, mandatory and in-service education programs that are provided via face-to-face education sessions and eLearning. Processes for orientation staff are well developed and supported with educational resources. The organisation reported that there is very low usage of agency staff. The mandatory training and competency assessment programs address the requirements of the NSQHSS. Maintenance of records of staff participation in education programs has been enhanced by the implementation of a new eLearning platform (ELMO). Records show very high levels of staff compliance in mandatory training and competency assessment requirements. The organisation is congratulated on the achievements in hand hygiene, aseptic technique, basic life support and medication management training.

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

The organisation-wide quality management system is very well- established and is integrated with the risk management incident, complaint/patient feedback system and supported with associated policies, a comprehensive range of audits, and a range of indicators for monitoring of performance. The RPH Hospital Safety and Quality Plan is developed annually and linked to the National Safety and Quality Plan. A very well-documented and comprehensive RPH organisation-wide Quality Action Plan and Ward/Unit Quality Plans are in use and reflect the organisation's quality priorities, incorporate the NSQHS, and target areas requiring improvements. There is widespread evidence of monitoring of progress, achievements with monitoring of performance being overseen by the RPH Quality Manager, Ward and Department Managers and the Executive team. Many quality improvement projects have been undertaken or are in progress. Notable examples include enhancement and improved integration of clinical models of cancer services and the establishment of a centralised cancer service (Ringwood Cancer Care), implementation of a range of strategies resulting in a significant decrease in falls incidents, development of a clinical handover video and a RPH patient information video. The surveyors have rated actions 1.6.1 and 1.6.2 as Met with Merit (MM).

Clinical practice

Clinical guidelines, a small number of clinical pathways and generic nursing management care plans are in use. The model of care for cancer patients is very comprehensive and supported with an Oncology Liaison Nurse, a Cancer Support Nurse, and multidisciplinary meetings for breast cancer patients. Management of flows of Medical patient flows is supported with a Medical Liaison nurse. Discharge planning is very well developed, commencing at the beginning of the episode of care, and is supported with case reviews. Processes are established for variance analysis of clinical pathways, ongoing review care plans, monitoring of length of stay of all patients and variances against expected ALOS. Mortality and morbidity data and ACHS indicator data is subject to regular review by clinicians, the Quality Committee and Patient Care Review Committee and the Executive.

There is a clear exclusion policy regarding patients who should not be admitted to RPH. Use of risk assessment tools is incorporated in the pre-admission assessments and completed in pre-admission and admission and ongoing patient management processes. Risk assessments include falls, malnutrition, pressure injury, and infection and cognitive status, allergies, VTE, medication risk and discharge risk. A distress risk assessment tool is used for all cancer patients.

Alerts are documented in the patient clinical record, the electronic administration information system and in other communication tools. At-risk patients are discussed at handover meetings. Management plans are developed for patients identified at risk. Audit results show good compliance with completion of risk assessments and implementation of appropriate management plans.

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

A suite of policies provides the framework for management and documentation of patient clinical records. Hard copy integrated records and electronic pathology results are available at the point of care. All patients have a unique identifier. Mechanisms are well-developed for the management of UR numbers, duplicates, timeliness of retrieval, tracking, and coding of records. Impressive work has been undertaken to reduce the incidence of duplicate records resulting a substantial decrease in the occurrence of duplicate UR numbers and improved timeliness of retrievals. The design of the clinical record facilitates ease of auditing processes and allows for NSQHS related audits to be completed. A HSP forms rationalisation project undertaken across HSP hospitals by the Corporate Office has been associated with substantial refinement and reduction of the forms in use at RPH. Results of clinical record documentation audits show evidence of good compliance with documentation requirements. Evidence provided showed there has been substantial improvement in completion of nursing discharge summaries within the required 48 hours of discharge. Clinical records sampled by the surveyors were found to be well documented.

Performance and skills management

Credentialling and defining scope of practice for medical officers occurs within the framework of the HSP By-Laws and RPH clinical services capability and is overseen by the RPH Medical Advisory Credentialling Committee. Applicants are required to provide evidence of credentials, referees, verification of insurance and details of scope of practice sought and a copy of a CV. An E-credentialling system is in use includes use of a database for management of applications and records, and approved scope of practice. HSP external credentialling audit results show 100% compliance.

AHPRA Registration of Medical Officers, nursing and allied health is subject to regular review. Appropriate processes for defining and monitoring the scope of practice of the nursing and allied health workforce are in use and include the use of position descriptions. The WebPas patient information system is linked to the e-credentialling and assist in monitoring compliance with approved scope of practice of medical officers. Operating theatre managers and Nurse Coordinators have access to the database to monitor approved scope of practice of medical officers.

Policy and procedure are available for the safe introduction of new interventional procedures.

Mechanisms for clinical supervision of nurses and allied health workforce and students are well-developed. New Nursing graduates are supported with a preceptor system and by a nurse educator.

Performance review of medical officers includes monitoring working within approved scope of practice, incidents, clinical outcomes and conduct. Annual performance development and review are undertaken for other workers, with 91% compliance reported.

Systems are well-established for the relevant clinical and non-clinical workforce to access ongoing safety and quality education The orientation program that is provided for hospital Quality and Risk Managers through the Corporate Quality and Safety Executive has been enhanced with the introduction of a podcast which facilitates flexibility in the participation of staff. Opportunities are provided by HSP Corporate for staff to participate in training in quality programs. Conferences for the health workforce that are conducted by the various HSP Clusters have been associated with an expansion of the programs offered. Records show good levels of RPH staff participation in safety and quality education programs. The HSP Governance Audit and evaluation of education programs are used to assess workforce understanding of quality and safety. Results of the 2016 Staff engagement survey, “Your Voice Counts” indicates staff perceive there is a very high commitment to quality improvement in the RPH day-to-day operations.

Incident and complaints management

The systems for management of incidents and complaints are well-developed, and supported by HSP and RPH policies/procedures and the use of RiskMan. This includes maintenance of registers of incidents /near misses and complaints, categorisation and risk rating of incidents and complaints according to severity. Management of incidents and complaints is overseen by the RPH Quality Manager and processes are established to ensure that the GM/DON is alerted when an incident occurs. Sentinel events are reported to HSP Clinical Governance Unit and are subjected to a critical systems review. Incidents are communicated to the workforce once confirmation and the initial investigation have occurred. Shared learnings are in use for sentinel events occurring within HSP hospitals. Monitoring of performance is overseen by the Quality Committee, Executive Team Committee and the Medical Advisory Committee.

Application of the National Open Disclosure Standard is undertaken in association with the investigation of incidents/complaints. Records show 98% of the clinical staff have completed mandatory training in the use of open disclosure processes.

Patient rights and engagement

RPH information regarding patient rights and responsibilities is consistent with the National Charter of Healthcare Rights and is available in the patient information directory, brochures, the HSP website and posters displayed throughout the facility, and is incorporated in the admission process. Access to interpreters is available. Results of the RPH September 2016 indicate 94% satisfaction of patients in understanding their rights and responsibilities and participation in decisions regarding their care. Bedside patient communication care boards are in use in all clinical areas to facilitate communication and partnering with patients and carers. A revised Nursing Care Plan, which is to be trailed at RPH in the near future, incorporates provision for patient's signatures to indicate participation in their care planning.

The systems for management of consent are well-established and are subject to ongoing monitoring and audit. Results of audits of consent for surgical procedures and show 100% compliance in documentation. Results of an audit of consent documentation for chemotherapy that was conducted during survey showed 100% compliance. The organisation is encouraged to schedule regular consent audits for chemotherapy patients to monitor compliance in documentation.

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

Hard copy clinical records are stored securely within the Medical Records Department on-site storage areas with only Clinical Information staff and after hours Nurse Coordinators able to access and distribute records. Impressive work has been undertaken in the refinement of the RPH on-site storage of medical records which has assisted in timeliness of retrieval of records. A privacy policy is available to the workforce and staff undertake privacy training. Access to all electronic information systems by staff is via restricted password protected procedures. Privacy and release of information protocols are made available to patients with evidence that they can access their health record information in a timely manner. Authorising procedures for use or disclosure of information outside the usual provision of care are well established.

NSQHSS Survey

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Data collected from Patient Satisfaction Surveys, HSP Patient Experience Surveys, Patient Journey surveys, complaints and compliments are used to gain feedback on patient experiences at RPH and for the development and implementation of actions plans for areas identified as requiring improvement. Results of patient satisfaction surveys show consistently high levels of satisfaction, with the average overall 2015-2015 patient satisfaction survey levels reported as 88.3%. Results of the June 2016 Day Procedure Unit patient satisfaction survey show 98% satisfaction. Results of the North Eastern Melbourne Integrated Cancer Service Patient Experience Survey of Day Oncology Patients May/June 2016 show RPH demonstrated very high levels of achievement in all the target areas surveyed. Results of the December 2016 RPH Patient Centred Care Survey show 58% satisfaction. The organisation is congratulated on these results.

Examples of quality programs implemented as the result of patient feedback include improved patient meals and management of food temperatures, purchase of fans and heaters to improve air temperatures in the downstairs clinical areas. Plans are in place for installation of silent nurse call system in the near future to reduce noise in patient areas.

Governance and quality improvement systems

Ratings

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

Action 1.2.1 Core

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

Surveyor Comment:

RPH collects data on an extensive suite of safety and quality indicators which incorporate the requirements of the NSQHS and risks identified in RiskMan, Healthscope 'never events,' and clinical indicators. Quarterly safety and Quality reports are submitted to the Corporate clinical governance team and performance is measured against targets, trended and benchmarked across HSP hospitals. Reports show all outliers which do not meet the specified performance targets and hospitals are required to submit action plans within a target timeframe of one week to address areas below target. RPH submits data to the ACHS clinical indicator program. Performance is monitored by the various RPH Committees and the Executive Management Team, the HSP National Safety and Quality Committee, and the Board. There is substantial evidence of a consistent, well-established and sustained organisation-wide approach for regular reporting of safety and quality indicators and other safety and quality data by RPH and monitoring of performance, and development and implementation of follow-up action plans for areas identified as requiring improvement. The survey team concurs that the rating of this action be increased to Met with Merit (MM)

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

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

Surveyor Comment:

The organisation-wide quality management system is very well- established and is integrated with the risk management incident, complaint/patient feedback system and supported with associated policies, a comprehensive range of audits, and a range of indicators for monitoring of performance. The RPH Hospital Safety and Quality Plan is developed annually and linked to the National Safety and Quality Plan. Very well-documented and comprehensive RPH organisation-wide Quality Action Plan and Ward/Unit Quality Plans are in use and reflect the organisation's quality priorities, incorporates the NSQHS, areas requiring improvements. There is widespread evidence of monitoring of progress, achievements and monitoring of performance is overseen by RPH Quality Manager, Managers and the Executive team. The surveyors agree that there is a very well-developed organisation-wide quality management system and widespread evidence of rigorous processes for ongoing monitoring/review of performance and concur that a Met with Merit rating is warranted.

Surveyor's Recommendation:

No recommendation

Action 1.6.2 Core

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

Surveyor Comment:

There is substantial evidence available demonstrating implementation of quality improvement actions to maximise the quality of care across the organisation and ongoing monitoring and evaluation of outcomes. KPIs, incidents. A large number of quality improvement projects have been undertaken. Notable examples include implementation of a range of strategies resulting in a significant decrease in falls incidents, enhancement and improved clinical models of care in cancer services, development of clinical handover video and RPH Patient Information Channel video. The surveyors agree that the rating of the action should be increased to Met with Merit.

Surveyor's Recommendation:

No recommendation

NSQHSS Survey

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Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

1.15.4	SM	SM
1.16.1	SM	SM
1.16.2	SM	SM

Patient rights and engagement

Ratings

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

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STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

RPH demonstrates a distinct focus on fostering partnerships with consumers and carers. The governance arrangements occur within the framework of the HSP Partnering with Consumers Policy and are well-established. Two Consumer Consultants are members of the RPH Quality Committee and meet regularly with the Director of Nursing and Quality Manager. The Consumer Consultants have clearly documented position descriptions and arrangements are established for participation in a comprehensive RPH orientation program. Mechanisms are well-developed for communicating the activities of the consumer representatives, to the Executive and staff. patients and carers.

RPH strategic planning activities incorporate feedback from consumers.

Evidence was available demonstrating that the Consumer Consultants have been consulted in the development and revision of publications/patient information materials and feedback incorporated in the documentation. A HSP logo, which has been developed in consultation with consumers, is used to indicate a Consumer Approved Publication and applied when an organisation demonstrates that required criteria are met. HSP is encouraged to develop documented guidelines to support the application of the criteria to be used in the development of documents) and listed in the HSP Consumer Approval Process (CAP) brochure a currently these are not comprehensively explained in the brochure.

Consumer partnership in designing care

Mechanisms for the participation of consumers in designing and redesigning care are established. Activities have included consumer consultation in the redevelopment plans and development and implementation of the RPH Lymphodema Clinic and refurbishment of the Lavender Room located in the Oncology Ward.

Evidence provided showed that patient-centred care education is incorporated in orientation, mandatory eLearning and in-service education programs provided for the workforce. Records show 100% participation in Orientation programs and 97% in the eLearning program.

Consumer consultants provide education to the workforce through meetings with staff which incorporates roles of the consumer consultants and feedback on patient surveys. Further work is planned to strengthen consumer involvement in the training of staff and includes proposed development of DVDs with inclusion information on the role of the consumer consultant and use of patient stories. The organisation is encouraged to implement a more structured approach for consumer participation in training of the RPH workforce.

Consumer partnership in service measurement and evaluation

Mechanisms are established for providing the community and consumers with information on the safety and quality performance of RPH and include the display of information on the My Healthscope website and throughout the hospital RPH. The Consumer Consultants participate in measurement and evaluation of services and safety and quality performance in association with their membership of the Quality Committee and their participation in quality activities. Evidence provided showed results of the patient journey surveys had been presented by the consumer consultants. There are several examples of participation of consumer consultants in quality activities and include patient journey surveys, projects related to food services, identification of content to be used on patient bedside communication boards and the RPH TV Patient Information Channel**.**

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

RPH has strong governance systems in place that includes the RPH Infection Prevention and Control Management Plan to assist with ensuring effective infection prevention and control (IPC) and minimisation of risk to patients.

Standardised Healthscope Group-wide policies, Healthcare Infection Control Management Resources (HICMR) policy manual and risk assessment audit tools are based on best practice principles and use nationally agreed definition for Healthcare Associated Infections (HAI), and encompass all aspects of IP&C identified in 3.1.1. Policies are subject to regular review and are available to all staff through the intranet and the HICMR portal.

The HICMR Consultants, supported by a RPH part time infection control coordinator, conduct hospital-wide audits of compliance against policy and practice using the ICP Risk Assessment Tool, and action plans based on the risk assessment are evident. HICMR provides a 24/7 service for advice and problem solving.

The Surveillance Program is managed using the HICMR program and this provides a consistent, evidence-based approach to the management, reporting and review of surveillance of HAI's. Pathology results are promptly reviewed by HICMR and reported to the relevant clinical area and copies provided for placement in the patient medical record.

Infection Control and surveillance program, performance monitoring and review of incidents are comprehensive, and results of surveillance are reported and reviewed through a well-defined committee structure that includes, ICP Cluster meetings, Infection Control, Medical Advisory (includes Antimicrobial Stewardship), Pharmacy, Work Health and Safety, Clinical Review and Quality Committees. Infection Control performance data is reported to National Quality Safety Committee quarterly.

RPH is committed to ensuring that the workforce is appropriately trained in preventing infection transmission. Resource folders and fact sheets are situated in all areas. The orientation program includes training in IPC and completion of mandatory competencies, such as the eLearning Hand Hygiene package and Aseptic Technique, and is reviewed annually for currency and effectiveness. Targeted in-services and quality improvement activities are conducted in response to issues/risk events raised and identified through risk reviews. Resources and information sheets, including communicable disease alerts are readily accessed via the RPH intranet and HICMR website.

Infection prevention and control strategies

Hand hygiene is a key performance indicator for RPH. The Hand Hygiene Program is well structured and is consistent with the National Hand Hygiene Initiative (NHHI). HSC Policies and procedures are in place to guide staff and are accessible via the HINT portal and hard copy. Education and training resources and eLearning program are compliant with the NHHI requirements.

Regular audits are conducted in all areas of the hospital for the '5 moments for Hand Hygiene' by HICMR and supported by a gold standard auditor and the Infection Control (IC) coordinator, using the Hand Hygiene Australia (HHA) audit tool. Results are provided to each department, submitted to (HHA) 3 times a year, displayed on the Healthscope website, and trended data is included in the HSP Clinical Quality KPI report where they are reviewed and benchmarked within the HSP group.

Results of quality activities have produced pleasing results with Hand hygiene compliance rate increasing from 78.5% to 92.09% over the past year. Visiting Medical Officers' compliance continues to be low and this has been highlighted as requiring targeted strategies.

Hand hygiene products are available inside all patient rooms and are audited for use and accessibility. Hand hygiene products are reviewed and trials conducted prior to the introduction of new products.

The Staff Vaccination Program is managed by HICMR and includes ongoing management and review of the staff health database and measurement and reporting of the percentage of staff receiving vaccinations. HICMR and RPH Policies and procedures are in place that align with National Guidelines and the Australian Immunisation Booklet and review processes to align with best practice guidelines are evident.

Staff Health Clinics are conducted by the trained staff immuniser and HICMR consultant during high-risk periods such as Influenza season. Influenza and Hepatitis B are offered free to staff. According to the database information the uptake of the Influenza vaccine was around 30% in 2016, however, it is felt that the actual percentage is higher with many staff taking the opportunity to access GPs and Pharmacies. The hospital is endeavouring to capture this data for measurement in 2017. Vaccines are stored in monitored fridges that use the Strive for 5 Guidelines for data logging, temperature and alarm. Annual audit of fridges is undertaken.

There are processes in place to manage consent and refusal to vaccinate and these are recorded in the database. Forms are available in the Staff Health Toolkit. Vaccine refusal data is recorded on the database and reviewed if a staff member is working in a high-risk area.

HSP pre- employment vaccination screening form is completed by staff prior to employment commencement and immunisation status recorded on the database.

The Infection Control Plan and relevant HICMR and RPH policies and appropriate processes are in place that encompass the requirements for the occupational health program. The Infection Control Coordinator attends Workplace Health Safety (WHS) meetings. Products and equipment are trialled and evaluation processes and Infection control involvement in the risk assessment were evident. Occupational exposures are monitored and occupational exposure kits, based on the Occupational management guidelines are available at all nurses' stations. Surgical patients sign a consent for testing of blood if a staff exposure occurs. Education and observational audits are conducted on the application of PPE and Transmission Based Precautions and results are consistently high. There is a section on RiskMan that allows for the inclusion of notifiable diseases and staff exposures, and are used to evaluate and treat risks of injury or infection. Healthcare workers undergo skin assessments in relation to allergies to hand hygiene products and work restriction protocols for infectious healthcare workers are in place. Quality activities are evident with Hand Hygiene and Aseptic Technique included on the Quality Action Pan.

Compliance with the use and management of invasive devices is linked to a number of policies including Urinary catheterisation, vascular access devices, and the single use policy and included in the Infection Control Plan. Devices are risk assessed and monitored for integrity by HICMR, and reviewed by the procurement group prior to purchase and implementation. Competencies and monitoring of insertion and removal protocols, including the IV Cannulation package and various in-service sessions, are used in conjunction with Aseptic technique and Hand Hygiene training. Compliance with protocols is audited and included in the Clinical Quality Quarterly KPI data and recorded on the education database. The Surgical Short Stay pathway has a section for charting invasive devices IV access/PICC insertions.

Aseptic technique is now an embedded process across the clinical areas with a process of thorough assessments of clinical procedures undertaken using aseptic technique, targeted education of all clinical areas, with attention to the high-risk areas, use of ANTT validated audit tools and reviewed at IC Committee. Due to a focused campaign on improving aseptic technique compliance is now 100%. Action 3.10.1 is assessed as fully met.

Managing patients with infections or colonisations

Policies, guidelines protocols and signage based on national guidelines are available to guide staff in the use of standard and transmission based precautions, these along with a dedicated Pandemic Plan are included in the overall IC Plan. Staff are supported in this practice through training and education at orientation, departmental in-services and mandatory eLearning packages that include sharps safety management. Additional training is provided on donning and doffing of gowns, food safety and infectious disease management.

Completion of the pre-admission patient information and screening of patients and pathology, assists with identifying patients with an infection or MRO and this facilitates appropriate interventions to be put in place. The Infection screening tool seeks to identify patients with a history of CRE, MRSA, VRE and ESBL.

Monitoring and review are evident with HICMR conducting monthly nosocomial surveillance audits and observational audits of cleaning, waste and PPE. Audit results and incidents recorded on RiskMan are used to identify issues of concern related to transmission based precautions and there is evidence in the Quality Action Plan that these are used to drive quality activities.

Patients with known infections have alerts placed in the medical record and on WebPas to highlight the need for appropriate accommodation and precautions to be implemented and information and resources are available on the intranet and in hard copy.

Processes are well developed for communicating a patent's infectious status whenever responsibility of care is transferred between service providers and facilities. Processes include; clinical handover sheets, transfer forms, patient transfer summaries and letters and nursing discharge summaries.

Antimicrobial stewardship

There is a well-structured effective Antimicrobial Surveillance (AMS) Program established that is well supported by Healthscope Executive. HSP and HICMR policies, Multidisciplinary AMS Eastern Cluster and corporate committee structure which provides a strong governance framework for AMS.

The expansion of the AMS committee to include the Eastern Cluster has improved the effectiveness of the program with increased auditing taking place, and an Infectious Diseases Physician roster to allow for prompt advice and referrals.

National antimicrobial prescribing guidelines are available electronically in all clinical areas, and a standardised formulary of restricted antimicrobials has been developed. There is a traffic light system that is used to identify antimicrobials that provide an increased risk to patients. A register of red alert antibiotics and usage of Meropenum are monitored by the Pharmacist.

Continuous monitoring of antimicrobial distribution, volume of use, and trends in use occurs across the hospital. Antimicrobial prophylaxis audits are conducted against high risk procedures e.g. Hernia Repair with mesh, and prescribing patterns are monitored and feedback is provided to Specialists prescribing outside the therapeutic guidelines.

Cleaning, disinfection and sterilisation

A suite of policies and procedures provides the framework to ensure the principles of infection prevention and control are practised in the processing of RMDs, environmental cleaning, waste, and linen management. Building maintenance and cleaning schedules and Standard Operating Procedures (SOPs) for daily environmental cleaning and use of cleaning agents are available in cleaner's areas in hard copy. These are checked daily and sign off of completion occurs. An Environmental Services Handbook is provided to all cleaning staff at orientation. Results of environmental cleaning audits show high levels of compliance. Chemicals are appropriately stored and MSDS are available at point of use. Linen services are well managed with appropriate storage and handling of clean and dirty linen. Audits and review processes were evident, with results showing high compliance.

Water and ice machines are tested for Legionella and to date have shown no growth evident. However, due to high number of immunosuppressed patients at RPH a review of the ice machines is taking place with a view to upgrading to a superior system that further reduces the risk of Legionella growth.

The risk assessment and gap analysis against AS4187:14 has been completed by HICMR. The Plan for compliance with AS 4187:14 has been completed and this demonstrate a planned approach to progress towards implementation.

Given the restricted space in the CSSD area, maintenance of AS4187 principles are adequately adhered to. The storage space has been reviewed by WHS and improvements have been made. To further improve storage, stock levels are now being reviewed with a view to reducing number of items stored in the CSSD area to free up much needed space.

Despite the limited space, clean and dirty areas are well defined and instrument trolleys, endoscopes and colonoscopes are covered when being transported.

Sterilisers and washer/disinfectors are validated and tested daily and print outs of parameters are kept and soil tests are in accordance with ISO 15883- 5. The paper-based tracking system is regularly audited and allows tracing of instruments to the patient. Compliance monitoring and recording of sterilisers and washers is thorough. It was identified in the HICMR risk assessment that due to the age of the ultrasonic machine it was unable to be validated. RPH have responded with the purchase of a new ultrasonic machine and evidence of this was provided at survey. Steam and water testing are evident and results are reviewed by HICMR and IC Committee. Sterile instrument trays have dust covers and daily and monthly cleaning schedules and integrity checking are in place.

Sterilising services competency-based tools, workbooks and equipment safety check sheets are available via the HICMR portal for staff who are involved in the decontamination and sterilisation of RMDs.

Communicating with patients and carers

Consumers have access to publications, including MRSA, VRE and Clostridium Dif brochures, and infection rates, Hand hygiene and infection rates are available on the My Healthscope website.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

Evidence showed 100% compliance of clinical workforce training in ANTT. The action is assessed as fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

RPH Pharmacy Committee is responsible for overseeing drug and therapeutic activities. Related committees are the Medical Advisory Committee and HSP Medication Cluster Committee. The RPH Pharmacy Committee meets regularly and membership includes RPH MAC Chairperson, a clinical pharmacist, NUMs & GM/DON and a pharmacist from Hospital Pharmacy Supplies (HPS) which is the organisation contracted to provide pharmacy services at RPH. This includes management of prescriptions, imprest medications, and preparation of chemotherapy agents on site.

HSP and RPH policies/ guidelines are available to support safe medication management and show evidence of ongoing review. The medication authority system, audit schedule, and risk register entries relating to medications are well established. Evidence showed that 99% of nursing staff had completed mandatory medication safety eLearning. Audits include Medication Safety Self-Assessment (MSSA), Clinical Excellence Commission (CEC) Indicators for Quality Use of Medicines in Australian Hospitals and National Medications Chart, and drug registers. Results of the February 2017 MSSA show 77% compliance. Action plans have been developed for areas identified as requiring improvement.

Strategies implemented to strengthen the management of medications include: patient identification improvements; use of the National Inpatient Medication Chart (NIMC); implementation of user applied labelling for injectables, the establishment of an after-hours medication cupboard; the introduction of a form for Calculation of PINCH drugs. The organisation is encouraged to document a procedure to support use of the PINCH Calculation form.

Medication incidents are recorded in RiskMan and performance is trended. A reflection tool is used to assist nursing staff education for the prevention and management of incidents. Learnings from the HSP Medication Cluster Committee are communicated to RPH clinical staff.

Documentation of patient information

Policies to support the clinical workforce in documenting accurate patient medication records are in use. NIMC and medical record documentation audit results show good levels of compliance with recording the patient medication histories and allergies. Policies and procedures are available for recording and reporting adverse drug reactions, including notification of the TGA. Mechanisms to monitor events include use of the incident reporting system. A very low level of adverse reaction events was reported by the organisation. Learnings from the HSP Medication Cluster Committee are communicated to RPH clinical staff.

Medication management processes

Electronic and hard copy references are available to support medication practice. The clinical pharmacist supports the medical and nursing workforce in medication management assisting with education in response to needs as well as in provision of ongoing programs.

Storage and distribution systems are well managed with appropriate storage of high risk and temperature sensitive drugs and disposal of unwanted, unused and expired medications. Reviews of imprest medications are regularly undertaken by NUMS & HPS Pharmacist.

Patients' own medications including Drugs of Dependence (DDs) brought into hospital are stored, used, accounted for or disposed of with their permission. Bedside lockable drawers are available for storage of patient medications, excluding DDs which are stored in secure drug cupboards in secured treatment rooms. Audits of DD registers are undertaken and good compliance with required documentation was reported.

Posters are present in the secured treatment rooms to identify high risk (PINCH) drugs. Plans are in place to replace current medication storage containers in treatment rooms and increase the size of the font used in Tall Man medication labels.

Continuity of medication management

Medications on patient admission, internal transfer and on discharge are well managed and are supported with specific policies. A tool is used to communicate medications, changes to medications in the clinical handover of patients.

Communicating with patients and carers

Documented medication information is available for provision to patients.

Evidence provided showed that there has been a substantial improvement in completion of medication management plans which is supported with audit results. Patients are risk assessed on admission and a clinical pharmacist completes medication profiles for all patients identified as at risk. Medication profiles are incorporated in discharge summaries prepared by nursing staff. Plans are in place for incorporation of electronic copies of medication profiles to be included with electronic nursing discharge summaries.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

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

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Ringwood Private Hospital
Orgcode : 220194

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

There is a well-established governance system for ensuring consistent and correct identification of a patient at any point of care. HSP policies and processes are used to guide staff through a standardised approach to maintaining correct patient identification and procedure matching processes from admission to discharge. HSP has 4 patient approved identifiers to be used. The WebPas information management system prints ID labels with the 4 patient identifiers with the use of the Zebra printer system. Discharge processes include a discharge checklist and patient information and patient transfer form as well as specific forms for individual specialty clinics and allied health.

HSP policies and protocols are extensive and cover all elements of patient identification, including Patient Identification (ID) Bands that comply with NSQHC specifications for a standard patient identification band, (red ID bands are used for alerts), Correct patient correct procedure and correct site. These practices are also included in a number of clinical policies, clinical handover, patient pathways and clinical interventions that require strict adherence to patient ID and include Team Time Out in theatre using the Surgical Safety Checklist immediately prior to a procedure, and for the administration of blood and blood products. The surgical safety checklist has a safety stop point marked in red that indicates the patient must not proceed this section has been completed.

The Healthscope clinical audit schedule includes review of documentation and audit for compliance with the use of 3 of the 4 approved patient identifiers, Correct Patient, Correct Procedure, Correct Site for theatre, and for orderly transport.

Key issues and mismatching errors are recorded in RiskMan and risk rated, analysed and reviewed by the Healthscope quality and risk team and data is included in the national quarterly safety and quality report. Feedback systems to staff include results of audits and benchmarked data, and this is used for discussion at staff huddles, education and to drive hospital-wide and individual ward quality improvement activities.

Processes to transfer care

A patient identification and matching system is in place and is regularly reviewed as part of structured clinical handover, transfer and discharge processes. Audit results show high levels of compliance.

Monitoring of the number of Bupa patients receiving post-discharge phone calls has been activated as an inclusion on the Quality Action Plan. The current rate of Bupa patients who receive post discharge phone calls is 75% against a target of 90% and has been highlighted for improvement. Discharge phone calls for all day surgery patients is 99.06%.

Processes to match patients and their care

Patient matching to care is optimised using individual processes and tools for clinical handover and patient and procedure matching, focusing on high-risk clinical situations. The surgical safety checklist has a safety stop point marked in red that indicates the patient must not proceed this section has been completed.

Education and training of all aspects of Patient Identification and procedure matching is provided at staff orientation, during the May Focus month, and ad hoc as required. Record of attendance at education sessions and completion of competencies are kept on education database.

The Patient ID Cluster Group discuss and review incidents and strategies to reduce risk to patients. A quality activity was activated in response to a Patient Identification near miss that had potentially put a patient at significant risk. RPH responded promptly to the incident and following review and discussion changes were initiated and an additional step was put in place at RPH reception for initial checking of patient ID prior to admission to the ward. There have been no further incidents since.

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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

Policies and protocols are comprehensive and cover all aspects and risks associated with Clinical Handover of patients during their care. These are linked to associated standards and protocols including patient transfer and discharge, shift to shift handover and patient pathways.

The Clinical Handover Action Plan and Cluster Quality Improvement Plan include Clinical Handover, and highlight strategies and activities to monitor and improve Clinical Handover practices and overall compliance. Numerous resources and tools are easily accessed through the HSP intranet including a comprehensive suite of handover tools that provide for thorough, consistent and effective handover processes from pre-admission, ward to ward transfer and discharge.

Incidents, near misses and adverse events are recorded on RiskMan and monitoring and review for outliers is evident with the number of quality activities conducted, as well as inclusion on the RPH Quality Action Plan, and reporting through the Clinical Handover Cluster group, RPH and Healthscope Quality Committees.

Clinical Indicator reports are included in the Healthscope Quality and Risk reports quarterly and benchmarked in the safety and quality database.

Clinical handover processes

Policies and protocols comprehensively describe the structure and the four minimum standards for clinical handover from preparation to transfer of patients.

All handover tools used at RPH support the ISBAR principles and are used at all points of inter and intra-clinical handover across all points of transition of care. Clinical guidelines for medical patients also includes ISBAR information is in all bedside clinical folders. A recent review of the patient handover in collaboration with the Radiology service provider has resulted in improved handover processes with the development of a dedicated checklist to be used for Radiology.

Information regarding care is displayed on communication whiteboards in patient rooms. Bedside handover is conducted daily between the am and pm shift and it was evident to surveyors that handover and whiteboard information is highly valued and appreciated by patients.

A number of surveys and audits are conducted to test the effectiveness of Clinical Handover. These include the patient satisfaction and patient impression surveys, bedside and medical record documentation and care plan audits. The Quality Action Plan highlights quality activities related to Clinical Handover with results of the most recent survey showing compliance increasing from 83% in 2016 to 100% at the most recent survey in 2017. This outstanding result was the outcome of focus groups, including Clinical Handover champions reviewing the audit tool for relevance, and changes and design being made.

Clinical Handover between Day Surgery Unit (DSU) and theatre was not formalised. CH process introduced between DSU staff and theatre holding bay and use of call bell when theatre staff ready for handover. Clinical handover between PACU/DSU staff is now acknowledged with the use of a stamp. Audit of clinical handover from DSU staff to theatre staff was a pleasing 100% at last audit. RPH is encouraged to continue the vigilance to Clinical Handover practices to ensure they are embedded throughout all areas of the hospital.

Patient and carer involvement in clinical handover

There was significant involvement of consumer in Clinical Handover evident to surveyors. Nursing care plans include a section for documenting that involvement of patients has occurred. A trial is being conducted to review the sign off by patients. Consumers were involved with the identification of the content to be used on the patient communication whiteboards, and the patient impression satisfaction survey and the mystery patient journeys include a review of clinical handover.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Detailed Healthscope Governance Systems are well documented in the Healthscope Safety and Quality Governance Plan 2016-2017 and includes safe and appropriate prescription and administration and management of blood and blood products.

A suite of HSP policies address based on evidence-based guidelines including, the National Blood Authority and National Health and Medical Research Guidelines, cover all elements of the clinical transfusion process, and provide the framework to support safe transfusion practices and management of storage and transport of blood and blood products.

A well-defined committee structure includes RPH working party, Eastern Cluster Group, Transfusion and local and national Quality Committees. The minutes of meetings are comprehensive, with evidence of review and audits of medical records, gap analysis and actions taken.

Committees monitor haemovigilance, including Clinical Indicators and KPI's pertaining to blood and blood products. Reporting and feedback mechanisms into risk management processes for adverse events, incidents and near misses are evident. RiskMan facilitates incident and trending reports on blood and incidents linked to the risk register where applicable, have sentinel event classification.

Monitoring and review processes are well established and embedded throughout the clinical areas with a number of clinical audits of blood and blood products conducted regularly.

Results of audits are used to drive quality activities and these are evident with the inclusion of blood fridge audit, blood consent audit and massive transfusion included on the RPH Quality Action Plan 2014-2017.

Education and training resources for blood and blood products is strongly evident at RPH and include; BloodSafe eLearning modules completed at orientation and annually, blood resource folders in all clinical areas, modules for orderlies, blood education month and presentations. Staff education is recorded and monitored on the staff education database. RPH sentinel learning compliance and action plan addresses the use of sentinel events to enhance learning.

Documenting patient information

A comprehensive risk assessment and history of transfusion forms an integral part of the medical record and included in the patient treatment plan, and must be completed prior to the administration of blood and blood products.

Policies and protocols for documenting transfusion details in the patient medical record are available.

The Quality Action Plan is an impressive document that has seen outstanding results achieved from quality activities involving blood documentation management. These include review and evaluation of the medical record and patient questionnaire, with audit results for documentation of blood consent compliance increasing from 52% in May 2016 to 100% in February 2017, Blood fridge audit increased from 83.6% to 100%, and a Massive Transfusion Protocol flow chart and kit was developed to support protocol outlined in the Massive Transfusion Policy. Results of documentation audits are presented at quality meetings and displayed in wards.

Consent for blood and appropriateness documentation compliance has been a focus for RPH. The Blood appropriateness audit conducted in 2015 highlighted deficits in documentation of Hb level. Actions were implemented by the Medical Advisory Committee (MAC) and an audit in February 2017 for blood appropriateness showed a pleasing 100% compliance with documentation requirements.

RPH has a strict policy – no consent, no transfusion. A poor compliance with consent in May 2016 was reviewed by the MAC. A letter was sent to VMOs and compliance in February 2017 was 100%.

Managing blood and blood product safety

Systems policies and protocols are established for the safe, efficient management, transport, storage, collection and wastage of blood and blood products. Australian Clinical labs and Dorevitch provide wastage reports, and monitoring and reports on blood usage is included in Healthscope KPI and clinical indicator data.

A new policy has been developed in response to changes in Immunoglobulin products commenced in Victoria in September 2016. VMO's and staff were formally notified of the change and the new BloodSTAR on-line system to facilitate authorisation, dispensing and reviewing of immunoglobulin products is utilised.

Incidents recorded on the risk register, where applicable, have sentinel event classification and incidents involving blood and blood products are reported to the National Blood Authority. Blood wastage is monitored and there was no wastage in the last quarter of 2016.

RPH risk register, transfusion risks, wastage, and consent are reviewed by the NUM, GM/DON and Quality Manager.

Incidents following pathology service are followed up directly with the pathology service and investigation and feedback occur. A significant breach in the cold chain cycle in 2016 activated a critical system review, and led to a review of policy, implementation of controls and education on blood cold chain competency for all staff. Completion of the competency was signed off by the staff member and assessor blood safe e learning.

Safe transfusion principles are used that include the three pillars of patient blood management i.e. optimise RBC mass, minimise blood loss and manage anaemia, and Team Time Out protocol is used prior to administration of blood and blood products and this is monitored through observational audits.

The mandatory BloodSafe eLearning module is completed by all clinical staff annually and blood transfusion administration is restricted to staff having satisfactorily completed the module. Records show 98% of nursing staff have completed BloodSafe eLearning.

The standardised blood register is audited and thermographs are monitored daily and changed weekly and kept for the life of the fridge plus 3 years.

Communicating with patients and carers

Patient information is available through a number of brochures available for patients receiving blood transfusion. These are included in the blood resource folder in clinical areas and are used to inform patients of the benefits and risks of transfusion. Patients are given brochures to read about blood products prior to administration.

A patient information sheet on blood transfusion, 'important information' is available in the patient bedside folder, and a patient information video from a consumer perspective 'what to expect during a transfusion' is available on the RPH TV channel.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

RPH has systems and protocols are in place for preventing pressure injuries, identifying pre-existing pressure injuries and to effectively manage pressure injuries should they occur. Governance occurs through the Pressure Risk Assessment Plan and Cluster and Quality Committees, where it is evident that KPI's and audit of policy and documentation results are reported, monitored and reviewed. Reports are provided to the national benchmark safety and quality data, Healthscope hospital division and Board. Feedback mechanisms are in place through the quality committee and ward huddles.

Wound and pressure injury screening and assessment are in line with the pan pacific guidelines. Skin integrity risk assessment and prevention and treatment strategies, based on the Norton risk assessment tool and Braden scale, are used for monitoring specific needs of patients based on their pressure injury risk and status. All pressure injuries (stage 1 and above) are reported on RiskMan.

Audit schedules are in place and are evident with several audits being conducted. The severe pressure injury – hospital acquired audit rate was 0.35% above the target of less than 0.04%. A number of improvement strategies were implemented including review of new charts to assist with accurate documentation, focused education and change in the indicator definition. Results overall have improved, however, owing to a cluster of stage 2 pressure injuries the December 2016 results were 0.28%. There have been no further issues since the peak in November/December 2016. This work is ongoing, however, the surveyors acknowledge the challenging casemix of patients at RPH and were impressed with the outstanding commitment to best practice principles for addressing this issue.

Preventing pressure injuries

Policies, protocols and guidelines are based on best practice and encompass all aspects of pressure injury management. Risk assessment processes include nutritional and malnutrition screening, continence and delirium. Purposeful hourly rounding charts, pressure turn charts and dietary charts are used for monitoring skin integrity and dietary requirements. Malnutrition identified as a key contributor to the deterioration of a patient's skin condition is monitored with the malnutrition screening tool and referral to a dietician is made for at-risk patients.

Manual handling education is conducted for equipment and pressure relieving devices, and educational resources and SOP's are available to staff for the operation e.g. hoists and lifters, and appropriate use of devices, such as mattresses and cushions.

A thorough visual skin assessment of skin integrity is monitored and documented daily at bedside clinical handover.

Managing pressure injuries

The wound management plan addresses mobility, skin assessment, nutrition, co-morbidities, pressure ulcer screening, continence, referrals and evaluation of patient outcomes. Pre-admission risk screening facilitates the advice to the wards of a high-risk patient prior to admission, and nursing discharge summaries include skin integrity status reporting. The perioperative record has a section that requires documentation of the strategies and equipment used in theatre for positioning.

Pressure relieving mattresses are used for most patients and air mattresses and used for patients that have been classified as high risk. Due to over 50% of patients at RPH being classified as high risk it is the goal of the hospital to have 75% of patients having air mattresses.

Nurse initiated referrals take place, based on the risk classification, to dietitian, physiotherapists, occupational therapists etc. and nursing discharge summaries include skin integrity status reporting.

Education on wound dressings and pressure injury prevention include mandatory eLearning modules, presentations, in service by standards champions, and records of attendance recorded on the education database.

Communicating with patients and carers

A number of resources for informing patients on the importance of the avoidance of pressure injury. The Move, Move, Move signage is placed in patient rooms as a visual reminder to patients. Patient information brochures were reviewed by consumers and included in the RPH admission pack and a patient TV channel has been developed for viewing by patients. Initiatives from the patient-centred care survey have also been implemented. A trial of air mattresses was conducted and patient involvement in the assessment was strongly evident.

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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

NSQHSS Survey

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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

RPH systems for recognising and responding to clinical deterioration are well-developed. Comprehensively documented policies/procedure provide the framework for implementation of measurement and documentation of observations, escalation of care, the rapid response system and communication processes. Development, implementation of the organisation-wide recognition and response system is overseen by the HSP Cluster Clinical Handover Working Party, the RPH Quality Committee and designated RPH Champions. The RPH Medical Advisory Committee also participates in evaluation of performance and quality improvements.

All deaths and cardiac arrests and the use of the recognition and response systems and any failures in these systems are subject to review. Data collected about the response and recognition systems is reviewed by the Patient Care Review Committee and the Medical Advisory Committee.

Recognising clinical deterioration and escalating care

Colour coded adult and paediatric observations charts are used for measurement and documentation of observations. Charts incorporate a track and trigger system which is designed on human factors principles and comprises trigger ranges for vital signs. Vital signs falling within the trigger ranges will require action as described on the chart (either clinical review or a rapid response), unless either altered criteria or Advance Care Planning / Limited Treatment Orders exist. Results of audits of the observation charts show good levels of compliance with completion of observations as per patient prescribed management plans. However, there is evidence of variable levels of compliance in graphing of observations and in completion of documentation when a change in clinical status has resulted in a clinical review. The organisation is encouraged to progress implementation of the action plan to address these aspects and increase monitoring of compliance to ensure there is sustained compliance in documentation requirements.

Responding to clinical deterioration

Track and trigger responses incorporated in the observation chart are used to escalate concern when observation parameters are outside normal ranges and a standardised handover process (ISOBAR) is used for transfer of information. When an assessment falls into the Rapid Response range or there is serious concern regarding the patient condition, clinical review is undertaken by the nurse in charge or the designated Visiting Medical Officer (VMO). The VMO attends for review and initiation of clinical care or directs a management plan per telephone that may include transfer to secondary hospital for assessment and treatment. A MET team operates within the hospital with well-identified criteria for calls. A mobile intensive care unit (MICA) supplied by Ambulance Victoria provide advanced life support and undertakes transfer of patients. MET calls, unplanned transfers to higher-level of care are subject to review by the Patient Care Review Committee and as required by the Medical Advisory Committee.

There was evidence indicating that 98% of nursing staff and allied health staff have completed BSL training. Action 9.6.1 is assessed as SM and is fully met.

A mandatory eLearning education program “Pulse Oxymetry and Monitoring of Oxygen Saturation Program” has been introduced as result of a HSP Clinical Governance Unit initiative following an adverse event in another HSP hospital Records show 96% RPH nursing staff have completed the program.

In 2016 RPH conducted a High Dependency Nursing Education Program with a view to increasing the knowledge and skills of nursing staff. A second course has been scheduled to occur in the near future.

ICU medical Officers and an on-call HMO from Knox Private Hospital provide e support the RPH HDU as required.

Emergency trolleys are subject to daily and weekly checks. Emergency Bag Seals and suction Equipment which are subject to regular checks are in patient rooms.

Communicating with patients and carers

The policy related to advance care planning, limitation of treatment and refusal of medical treatment is comprehensively documented. The formal procedures to be followed are clearly documented, including when treatment is to be refused for persons who are not capable of making their decisions. An Advance Care Directive brochure is also available Documentation of plans and alerts are incorporated in the clinical records.

Admission procedures, a brochure and patient bedside communication boards are used to communicate to patients/ carers information on how to communicate and escalate concerns about a patient's condition. A patient call system is available at the bedside and is subject to regular checking.

Evidence was available indicating that evaluation of patient escalation and response system is undertaken. A survey in 2016 undertaken by the Consumer Consultants showed 91% of patients knew what to do to escalate care. The organisation is encouraged to schedule regular evaluation to determine the effectiveness of the family escalation of care process.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

Evidence provided showed 98% of the nursing and allied health workforce has completed BLS training. The action is assessed as fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Ringwood has in place a dynamic approach to falls prevention and minimisation of harm from falls that is supported by a rigorous governance structure. There is a number of evidence based corporate policies and procedures available based on best practice and ACSQHC guidelines, that encompass the requirements for falls prevention and management.

Document control that includes a policy register and archiving is established, and all policies are authorised by the Healthscope CEO or Chief Medical Officer. This provides consistency and standardisation throughout the Healthscope Group of Hospitals. These policies are supported by the RPH policy manual that provides for the specific requirements of the hospital.

Screening tools available for identification of 'at risk' patients are used in conjunction with the manual handling assessment. The Patient Health Questionnaire has a preliminary falls risk screen and The Falls Risk and Management Tool (FRAT) directs clinical staff to a comprehensive assessment of patients that includes physical and psychological factors. The risk rating assessment indicates interventions based on risk rating and includes mobility aids, environmental factors and footwear to be implemented. Interventions also include medication review, referral to a pharmacist, physician and physiotherapist.

Falls incidents and accidents are reported and trended on RiskMan and benchmarked against Healthscope national KPIs for falls prevention and management. Performance data is reported through the extensive committee structure, from RPH Falls Working Party through to Cluster and RPH and Group Quality Committees. Regular compliance audits of the medical record and Falls Risk Assessment and Management Tool are conducted and this is evident with the inclusion on the Quality Action Plan that includes improvement activities and outcomes achieved.

Screening and assessing risks of falls and harm from falling

Application and commitment to increasing the proportion of 'at risk' patients for falls is embedded throughout the clinical areas.

The Falls Risk Assessment and Management Tool (FRAT) is based on the 'Preventing falls and harm from falls in older people' best practice guidelines. This tool identifies 'at risk' patients with a thorough assessment of risk factors that include; patient over 65, mobility, sensory deficits, continence status, cognitive issues, vision and medication issues.

Patient's falls risk assessment is conducted at pre-admission, and reviewed on admission to hospital. If indicated the (FRAT) is completed and the patients are re-assessed following surgery, changes in physical/psychological condition, post fall and ward transfer. Patients are reviewed daily at bedside handover.

Comprehensive audits and data collection are conducted of the medical record documentation and completion of the FRAT, including vigilant monitoring of changes to treatment/interventions when clinically indicated. There are many examples of review and gap analysis of policy and screening requirements, as well as incidents recorded on RiskMan being used to drive quality improvements, and inclusion in the Quality Action Plan.

Quality improvements include April Falls focus month, falls working party, hourly rounding, patient and carer education, introduction of falls champions, new signage to remind patients to use their frame. Review of best practice by the Falls Working Party has resulted in the recent addition of nocturia being added to the Falls Risk Form.

Falls education is conducted at orientation, department level huddles, review at the bedside and through the eLearning competency based training database.

Outstanding results are evident with the high percentage of compliance with completion and review of the FRAT and the increase in the number of patients being assessed and monitored. Surveyors have rated 10.6.2 and 10.6.3 as Met with Merit (MM).

Preventing falls and harm from falling

There is a strong reporting culture of the status of at risk patients. This is evident with well documented strategies and interventions recorded in the FRAT and the patient care plans in the medical record.

There is recognition of specific conditions and falls risk of paediatric patients with the introduction of falls information brochure for parents of children.

Observational audits of clinical handover ensure that patient risk is reviewed and communicated in the handover process.

The Falls Incident Reflection form completing by the nurse caring for the patient at the time of a fall allows for non-judgmental identification of contributing factors to a fall and follow up discussion and reviewed actions with the Clinical Manager.

There is a multidisciplinary approach to falls management, with the diverse membership of the Falls Working Party, and clear processes for appropriate referrals of patients being assessed at risk to physiotherapists, pharmacists, physicians etc.

There are numerous resources and tools utilised by patients and staff that provide strategies and information to minimise the risk of a fall. These include, the STOP remember your frame poster, call don't fall signs and falls symbols at the point of care.

All falls are investigated and dependent on the level of harm undergo a case review and if indicated acritical systems review. Findings are reported through the RPH and Group Cluster and Quality committee structure as well as to the National Clinical Risk Manager at HSP Corporate Office

Staff are educated in the use of appropriate preventative strategies through the orientation process, eLearning on line program, discussion at handover and staff huddles.

Patient falls risk status and implemented preventative strategies and handed over whenever care responsibility is transferred. This includes the e discharge summary to General Practitioners, referrals to relevant health professionals and assistance with the provision of mobility aids if required.

Communicating with patients and carers

Communicating with patients and carers is a key component of the falls management at RPH. Consumers are involved in the development and review of the Healthscope and RPH patient brochures and information booklets. All patients assessed as at risk and carers are provided with the 'Falls can be prevented' booklet published by the Australian Government, Department of Health and Ageing, and the Healthscope 'Keeping a step ahead of falls' brochure.

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An information flyer on specific falls prevention for children is provided to parents of paediatric patients.

Consumer representatives are active participants in the RPH Quality Committee where KPI's and results of audits in relation to falls is discussed.

The consumer representatives conducted a survey for the Hospital using a questionnaire for patients on fall prevention information.

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	MM
10.6.3	SM	MM

Action 10.6.2 Core

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

Surveyor Comment:

There is a high rate of compliance with the completion of the falls risk assessment tool, with a strong focus on measurement and review taking place.

The RPH Action Plan identifies a number of actions/outcomes resulting from audits. Achievements include a substantial increase in the number of patients screened for falls risk, being 80% in 2015 to an excellent result of 97% in 2016.

The Falls Risk Assessment completed within 24 hours of admission is 100% and this has shown to be sustained over the past two years. Falls incidents are reported, trended and benchmarked against the Healthscope Group target. Trended graphs of audit results and 'days since last fall' are displayed in all areas, and these show sustained results. There is a strong committee structure for reporting and review, ranging from RPH Cluster Committee to RPH and Group Quality Committees. The surveyors agreed that there is a well-established, systematic, hospital-wide approach to monitoring and identification of 'at risk' patients with evidence of a high level of compliance for risk assessment and management of falls. Surveyors agree that this action warrants a MM rating.

Surveyor's Recommendation:

No recommendation

Action 10.6.3 Core

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

Surveyor Comment:

There is a well-established falls management program in place at RPH for identifying and managing patients who are at risk of falling or who suffer from recurrent falls. A comprehensive team approach and commitment is evident throughout the organisation to ensure that all 'at risk' patients undergo a falls risk assessment. Incidents are recorded and trended in RiskMan and used for 'post incident falls' data reporting and analysis, and benchmarking. Audits of the medical record show a high compliance with implementation of falls preventative strategies and nurse referrals to physiotherapist and pharmacist. There is an all-inclusive, well-established approach to education of staff, with high compliance with completion of eLearning packages, discussion of falls risks and interventions at bedside handover daily, and ongoing monitoring and review of falls risk assessment documentation. Results of audits show that falls interventions have increased by over 20% in the past year, and this has resulted in a steady decline in the number of falls occurring. There is evidence of comprehensive falls indicator data being regularly reported and reviewed through an extensive committee structure ranging from falls working party through to Cluster and RPH and Group Quality Committees. Surveyor agree that the organisation has a well-established, comprehensive program in place for patients at risk of falls, with strong evidence of actions and evaluation leading to improvements in compliance and improved patient outcomes. Surveyor agree that this action warrants a MM rating.

Surveyor's Recommendation:

No recommendation

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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

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

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	SM	SM

	response to complaints		
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	SM	SM

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

- waste management within the clinical environment
- laundry and linen transportation, cleaning and storage
- appropriate use of personal protective equipment

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

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

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

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,	SM	SM

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

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

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation : Ringwood Private Hospital
Orgcode : 220194

Recommendations from Current Survey

There are no current recommendations.

Organisation : Ringwood Private Hospital
Orgcode : 220194

Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Incident and complaints management
Action: 1.16.2 The clinical workforce are trained in open disclosure processes

Recommendation: NSQHSS Survey 0514.1.16.2

Recommendation:

Provide training on Open Disclosure for relevant clinical staff.

Action:

e-Learning Open Disclosure Package which has been allocated to all staff. 100% pass rate required.
e-Learning database maintains attendance records of training. Report of training completion is available monthly to Department Managers.
Open Disclosure eLearning package is completed by clinical staff. Database is maintained by Nurse Educator
Open disclosure is practised at RPH relating to incidents and complaints
Incidents of open disclosure are recorded in the RiskMan patient incident entry under the journal entry
HSP Hospital By-Laws: medical staff continuous disclosure
Shared Learnings note implementation of Open Disclosure policy, including roll out of learning package for clinical staff

Elements of the Open Disclosure policy are:

- apology or expression of regret
- factual explanation of what happened
- opportunity for the patient to relate their experience of the incident
- potential consequences
- steps being taken to manage the event and to prevent recurrence

Steps of the Open Disclosure Policy are:

- detecting and assessing incidents
- signaling the need for open disclosure
- preparing for open disclosure
- engaging in open disclosure
- providing follow up
- achieving closure
- maintaining documentation
- recording of disclosure

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

Completion Due by: July 2014

Responsibility: N.Hall

Organisation Completed: Yes

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

Evidence provided showed that 93% of the clinical workforce has completed Open Disclosure training. The recommendation is closed.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Recommendation: NSQHSS Survey 0514.2.8.2

Recommendation:

Identify and implement a mechanism to engage consumers and carers in the planning and implementation of quality improvements.

Action:

Volunteer group currently do patient visits in the ward areas, and provide feedback to executive of any feedback they receive from the patients in the hospital during their visits and any other relevant feedback from their experiences when out in the ward environment.
Two new consumer Consultants have been appointed and have been actively involved in the following

- Meeting patients on the wards and completing patient surveys on areas such as falls and prevention prevention, hospital experience, gaining insight as to what is important to them whilst in hospital
- Presenting this information at the quality meeting about their experience and the information received from the patients and providing suggestions
- Reviewing brochures/ patient material in line with our consumer approved publication endorsement
- Reviewing information for our patient information TV channel
- Attendance at corporate consumer focus group
- Meeting with General Manager/DON with discussion around the introduction of Lymphodema clinic and the need in the community, also the strategic direction of the hospital with the proposed hospital expansion and new service.

It was identified in the local area from consumer feedback that there was a need for a Lymphodema clinic as the local public health sector had closed the one they operated, which left the community in desperate need of a service, we are currently working to offer a clinic at Ringwood with the commencement in July 2016.

Feedback from family member during meeting with General Manger/DON that there was need for availability of other therapy options such as massage, aromatherapy, project currently being worked on to introduce these into our oncology setting.

Cancer support satisfaction survey identified the need for counselling, counselling introduced as part of cancer support service.

HSP Policy 1.05 Consumer, Partnering with

- Position Description
- Minutes from HSP Clusters, Safety & Quality Committee and Department Head Committees.
- Patient Focus Groups
- PCC program
- Patient Satisfaction Survey Compliance with HSP Policy 1.05 Consumer, Partnering with
- Consumer Representative: provides feedback on PSS results
- Consumers involved in Safety and Quality performance review including feedback on My Healthscope data

Quality improvements with Consumer Representative participation includes:

- patient communication boards
- in-service education
- patient journey reports
- patient interviews
- myhealthscope reviews: data, presentation and performance
- patient information brochures
- Consumer Representative role' to inform staff of consumer participation at RPH
- Patient feedback on meals
- Consumers consultants participated food tasting and provided feedback
- Consumer board at reception
- TV Channel project
- Noise reduction project

Completion Due by: Dec 2015

Responsibility: N.hall

Organisation Completed: No

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

Evidence provided showed that consumer consultants are members of the RPH Quality Committee and have participated in planning and implementation of quality projects. Examples include projects related to food, identification of the content of information to be included on patient bedside communication boards, implementation of patient surveys and collation/review of results, development of the RPH patient TV information channel. The recommendation is closed.

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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

Recommendation: NSQHSS Survey 0514.3.10.1

Recommendation:

Ensure that all clinical staff are trained in aseptic technique.

Action:

HSP Policy 8.38 Aseptic Technique
Orientation program:

- infection control session includes hand hygiene and aseptic technique information
- record of attendance kept on education database

HSP eLearning packages include:

- hand hygiene
- aseptic technique - theory
- aseptic technique - practical
- invasive device education: IV cannulation, urinary catheter insertion, epidural catheter line management
- Theatre scrub competency
- RPH Aseptic technique assessments: IV line maintenance, IV line insertion, urinary catheter insertion, simple and complex wound dressing, surgical procedures
- Target facility's highest users of the highest risk devices then extend to all users.
- Education database is maintained by Nurse Educator and distributed to Senior Nurse Management team twice per month.
- Percentage of clinical workforce deemed competent in aseptic technique is reviewed and action to improve compliance is discussed at IC Committee
- HSP Infection Control Cluster and RPH Infection Control Committee: Evaluation of education and competency-based training resources.

Completion Due by: Dec 2015

Responsibility: N.Hall

Organisation Completed: No

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

Ringwood Private Hospital has a rigorous education program in place for the training of clinical staff in ANTT. Evidence showed 100% compliance.

The survey team is satisfied that this recommendation has been met.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 0514.4.14.1

Recommendation:

Ensure that an agreed medication management plan is documented and available in the clinical record.

Action:

HSP Policy 8.75 Medication Management Plan

- HMR Medication Risk Assessment in place
- HMR Medication Management Plan is inclusive of the medication management action plan
- MMP is retained in the patient medical record

Medication profiles are provided to patients:

- selection criteria apply
- copy of medication profile remains in the patient medical record

- Patient satisfaction is assessed on pain management:
- Patient centred care program survey
- Patient Impression surveys
- Medication management plan risk assessment form HMR 10.5
- Medication management plan HMR 10.3
- Audit of Medication Management Plan
- Patient clinical records show evidence of medication information being provided

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

Completion Due by: Dec 2015

Responsibility: N.Hall

Organisation Completed: No

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

Evidence provided showed that there has been a substantial improvement in completion of medication management plans which is supported by audit results. Patients are risk assessed on admission and a clinical pharmacist completes medication profiles for all patients identified as at risk. Medication profiles are incorporated in discharge summaries prepared by nursing staff. Plans are in place for incorporation of electronic copies of medication profiles to be included with electronic nursing discharge summaries in the near future. The recommendation is closed.

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

Recommendation: NSQHSS Survey 0514.9.6.1

Recommendation:

Ensure that RPH allied health staff complete BLS training.

Action:

HSP Policy 4.10 Training - Mandatory
HSP Policy 8.42 Basic Life Support (BLS) and cardiopulmonary Resuscitation (CPR)
Evidence:

1. HSP Policies are accessible to all staff via the Healthscope Intranet (HINT).
2. Education:
   - 2.1 hospital orientation: basic life support session included in hospital orientation
   - 2.2 eLearning education package available to workforce: basic life support
   - 2.3 competency assessments for basic life support,
   - 2.4 E-Learning data base records attendance at hospital orientation, practical competency assessment and annual mandatory training.
   - 2.5 Staff attendance records maintained by Educator
   - 2.6 monthly reports sent to DON & NUM"s
   - 2.7 Committees:
   - 2.8 HSP Clinical Clusters
   - 2.9 HSP Clinical Deterioration working group
   - 2.10 HSP Education Meeting
   - 2.11 Cluster meeting minutes include actions

2.12 RPH Quality Committee

3. Healthscope Shared Learnings:
4. Agency staff: contract compliance includes staff engaged to work at RPH have been assessed as competent in Basic Life Support
5. Mandatory training rate for BLS is 92%. This includes allied health staff and nursing staff.

Completion Due by: June 2014

Responsibility: N.Hall

Organisation Completed: Yes

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

Evidence provided showed 98% of the nursing and allied health workforce has completed BLS training. The recommendation is closed.

Organisation : Ringwood Private Hospital
Orgcode : 220194

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

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**

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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**

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

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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 : Ringwood Private Hospital
Orgcode : 220194

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**

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	41	3	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	16	2	18
Total	**204**	**5**	**209**

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

NSQHSS Survey

Organisation : Ringwood Private Hospital
Orgcode : 220194

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	50	3	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	18	2	20	Met
Total	**251**	**5**	**256**	**Met**