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

Sydney Southwest Private Hospital

Liverpool, NSW

Organisation Code: 12 03 03

Survey Date: 30 May – 1 June 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

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.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
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Survey Overview

Sydney Southwest Private Hospital (SSWPH) Executive and staff are to be complimented on their commitment and dedication to ensure systems are in place to deliver care safely. Managers, Visiting Medical Officers (VMO's) and staff, as well as community representatives were very engaged in the survey and their contribution was extremely valuable. Meetings were held with key committees and staff, as well as visits to all departments and services.

Major capital has been provided by Healthscope Corporate Office and invested to upgrade current clinical departments and fund the new building redevelopment project which includes new Theatres and a Central Sterilising Supply Department (CSSD) to be completed early 2018.

The hospital should be proud of their good work thus far and their achievements in improving care and services.

The surveyors appreciated the information provided prior to the survey and at the time of the survey. Evidence was available to support the hospitals self-ratings of Satisfactorily Met (SM) in all Quality Health Service Standards (NSQHSS) Core Actions.

The previous recommendation has also been closed.

Significant progress has been achieved in relation to the developmental actions and the two prescribed actions, Training in Aseptic Technique and Basic Life Support. Quality and Safety Action Plans, staff education and training, as well as competency assessments are in place to address further improvements. Evaluation is occurring and remains ongoing.

The survey team has also acknowledged two significant projects undertaken for Standard 9 and awarded Met with Merit (MM) for core actions 9.5.1 and 9.6.1. Both projects have clearly demonstrated the hospitals innovation and commitment to patient safety.

Further comments and suggestions for improvement have been included in the Standard Summaries.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Sydney South West Private Hospital (SSWPH) has a wide set of policies and guidelines in place to address governance and quality. Healthscope Corporate has a framework for patient safety & quality care by which the hospital's clinical governance is managed. The dimensions of Quality and Risk Management are well described and it was evident when reviewing and talking with the Executive and staff that these principles are embedded in every day practice. The hospital has a Risk Management Plan and Risk Register which is linked to the Quality Plan. The register provides guidance on how risks can be identified, categorised and managed overtime. There is also the Corporate Risk Management Plan which underpins and supports quality and risk activities hospital wide. The impact on patient safety is reflected in the Brownfield development having plans to incorporate patient flow as one of the prime movers in this development.

Clinical practice

SSWPH has recently implemented clinical pathways in various units and they are encouraged to continue to roll these out across the clinical areas. As these are new initiatives, SSWPH needs to continue to monitor the use of these pathways. There are mechanisms in place to improve the safety of patients at risk and these are done primarily by a pre-admission clinic and review. The clinical pharmacists contribute significantly to reducing the risk of treating inpatients. Deteriorating patients are well cared for.

Performance and skills management

The hospital has a very good education program in place to support the staff to enable them to carry out their duties in a safe and dependable fashion. There are structured learning processes with good orientation for both permanent and locum staff. SSWPH uses a central locum service to supplement their full-time staff and this service is accredited by Healthscope. Mandatory training shows over 92% of staff have completed all aspects of this important criteria.

Healthscope have policies and procedures in place regarding credentialling for clinicians including defining the scope of practice for all Visiting Medical Officers (VMOs). Scope of practice for doctors is aligned to their specialty and clinical services provided by the hospital. The Medical Advisory Committee (MAC) is active with good representation from the craft groups. Minutes of their meetings show knowledge an appreciation of the various scope of practices of the medical staff. These are monitored well and are consistent with the resources that SSWPH can provide.

A good initiative noted is the use of an external provider for support and supervision to individuals when help is needed. This can involve help with personal issues that may reflect on their ability to fulfil their duties at work. Nursing staff have a mandatory 12-month work performance and the medical staff have a five year re accreditation process with new referees required.

Incident and complaints management

Incidents and complaints are reviewed by all levels of management and the shared learnings of Healthscope is a valuable tool to inform all of their organisations of potential problems that may be flagged at only one of the hospitals. The electronic Incident Reporting System RiskMan is used to capture all incidents, hazards, near misses, complaints and risks.

Incidents are monitored diligently with clear escalation procedures in place. The Executive and managers are to be congratulated on their commitment to ensure near miss reporting is encouraged and acknowledged.

Feedback of incidents is disseminated through various committees as well as one to one education sessions on the wards and service departments.

The National Open Disclosure Policy has been adopted by Healthscope and implemented at the hospital. There is open disclosure training available.

Patient rights and engagement

Healthscope has implemented the Australian Charter of Health Care Rights which underpins the fundamental rights of all patients. Consumer participation is valued and feedback provides advice to the Executive regarding hospital facilities and community needs.

The hospital has implemented a number of initiatives to enhance the patient experience. Audits of patient expectations have been done and show overall satisfaction with all aspects of their experience at the hospital. There is a consumer group who work closely with management. The committee is extremely proactive in this regard.

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Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM

1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

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STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The hospital has a well-established Consumer Consultant Committee who work closely with the General Manager and Executive to improve the patients experience when admitted into the facility. The committee has a set agenda which includes changes to services and service planning. When speaking with the consumers it was clearly evident they were very passionate about their role and are committed to assisting the hospital in identifying areas to improve customer satisfaction.

There are consumer representatives on craft groups such as Maternity, who are a valuable resource in providing feedback for areas for improvement. Results from such feedback has given Midwives the responsibility for all bookings. This has increased the relationship and satisfaction by parents and enhanced the continuum of care.

Consumers are included in education and training at orientation, particularly in relation to privacy and confidentiality, as well as providing new staff with information regarding their role in customer service.

Consumer partnership in designing care

Consumers are well informed regarding patient-centred care initiatives and care planning. Results from Patient Satisfaction Surveys are reviewed regularly. Purposeful Patient rounding is supported by the consumers and the REACH program (have your say) leaflets are encouraged to be used. White boards in patients rooms are also in place for this purpose and a flow chart is available as a prompt for patients to ask questions regarding their care.

The introduction of the Mystery Patient Questionnaire is a great initiative, whereby a patient is asked to track their journey from the time of pre-admission through to discharge. The pilot program appears to have been very successful. The hospital is encouraged to include this patient journey questionnaire as part of their suite of patient satisfaction surveys.

Consumer partnership in service measurement and evaluation

A wealth of information is provided to patients and families regarding hospital care and services. The Consumer Consultant Committee is well engaged in ensuring patients and families are provide with up-to date-information.

The committee review results from patient satisfaction surveys, compliments and complaints and have significant in-put into the publication of booklets and brochures. The website is also another area consumers can access information and provide feedback.

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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

The infection control system is well established and managed diligently. HICMR, the Infection Control Consultants provide a comprehensive range of evidence-based policies, procedures and audit tools in accordance with the Australian Guidelines for the Prevention and Control of Infections in Health Care. The hospital, in consultation with HICMR may wish to consider risk rating their policies in the future to provide easy access for staff in this regard.

The Infection Control Management Plan toolkit is comprehensive and managed by a dedicated multidisciplinary Infection Prevention and Control Committee.

The risk management approach to infection prevention is highly impressive. Safety and Quality Action Plans have been implemented in accordance with the identified risks documented on the risk register, for example, Sterilisation and CSSD AS4187 compliance.

Infection control surveillance is monitored through, pathology results, risk assessments and screening, incident reports and compliance audits. Monthly reports are tabled at the Infection Prevention and Control Committee and disseminated to the Medical Advisory Committee (MAC) and all departments. Clinical indicators are reported and benchmarked across the Healthscope Hospital Group.

SSWPH's low infection rate is testament of the robust systems in place to monitor infections across the hospital.

Infection prevention and control strategies

Hand Hygiene is deemed a high priority and continues to be reviewed and evaluated throughout all clinical and non-clinical areas in accordance with the hospitals Hand Hygiene Management Plan and hand hygiene guidelines. Staff education commences at orientation and regular information sessions are conducted internally and externally. ELMO eLearning packages are required to be completed as part of the education program. The hospital has increased the number of Gold Standard Auditors and there is a plan to provide more education for managers and staff in the five (5) moments auditing process. Results from audits are reported to the appropriate committees and departments.

Consumers are also able to view results on the MyHealthscope MyHospitals Website.

The staff immunisation program is well documented and monitored in line with corporate and national policies. The staff health program includes staff health assessments and screening, vaccinations and education and training. Staff are encouraged to participate and contribute to their wellbeing. Patients are also included in education and vaccination programs.

Policies, procedures and audits are in place to enable the hospital to manage the use of invasive devices safely. Intravascular device management guidelines and competency-based training tools and flowcharts such as, the Body Fluid Exposure Flowchart are used to ensure clinicians are provided with education applicable to their discipline.

There has been considerable work undertaken in regard to Aseptic Technique. Procedures have been identified and competency-based assessment tools are linked to “high risk” clinical departments such as, Maternity and ICU as a priority to enable the hospital to monitor medical and nursing staff compliance.

Visiting Medical Officer's (VMO)'s and Contracted Medical Officers (CMO)'s working in these departments are included in Aseptic Technique education. Compliance at present ranges from 76% to 92%.

Further education for low risk departments is ongoing and action plans are in place to improve compliance.

Managing patients with infections or colonisations

Standard precautions and transmission based precautions are monitored regularly according to policies and procedures and national guidelines. HICMR audit toolkits are used to evaluate adherence to policies. Results are reported and acted on in a timely manner. An alert system on the Patient Administration System (WebPAS) is in place if a patient has been identified as a risk. The patient can be tracked at all times through their care episode. Isolation procedures are in place if the need arises. Patient information is available and signage is posted in all departments and public areas. Environmental cleaning schedules and Food Handling competencies are comprehensive and results reviewed regularly. A high level of compliance has been achieved.

Antimicrobial stewardship

The maturity of the Antimicrobial Stewardship Program continues to provide good evidence of improvements associated with antibiotic usage and prescribing patterns. HPS Pharmacy in consultation with the VMO's are to be congratulated on their good work to reduce the use of antibiotics for Joint Replacements, Caesarean Sections and Paediatrics. Traffic light reports are also used to identify compliance to antibiotic appropriateness and prescribing patterns which is highly impressive. HOSPITAL NAPS National Antimicrobial Prescribing Survey is used to address adherence to guidelines and the appropriateness of Antimicrobials. The results thus far show an overall compliance of 60-69%. Clinicians are well engaged and work closely with the microbiologists and pharmacists in this regard.

Cleaning, disinfection and sterilization

The hospitals cleaning, disinfection and sterilisation practices are managed well by a dedicated clinical workforce. AS4187, GENCA guidelines and ACORN Standards are used effectively to audit compliance.

The design and layout of the current CSSD and the segregation of clean and dirty remains a challenge for staff, however there are good processes and risk minimisation strategies in place to manage the risks.

The new theatres and CSSD will be most welcomed.

Staff are continually provided with education and training and all competencies are documented.

Instrument tracking is in place and all validation records are recorded for instrument sterilisers, dishwashers, ultrasonic's and dryers. The reprocessing of scopes is also diligently monitored and recorded. There has been some very good work conducted in regard to the segregation and location of sterile stock and the introduction of custom packs to eliminate the use of linen. Well done.

Environmental audits, as well as Food Safety Audits are conducted regularly. Results continue to indicate a very high standard is being maintained.

Communicating with patients and carers

It was evident at the time of the survey that the hospital is very well engaged with patients and consumers in relation to infection control prevention.

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Information regarding hand hygiene is well displayed in all clinical departments and pre-admission and assessment tools also provide patients with information regarding risk factors and the management of infectious diseases. Feedback is sort and evaluation occurring.

The hospital is encouraged to keep up the good work.

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:

Procedures and services have been risk rated and there was good evidence to support clinical workforce training in aseptic technique.

Surveyor's Recommendation:

No recommendation

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Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

Healthscope Corporate Office have invested significant capital in relation to a redevelopment which includes new theatres and a CSSD anticipated completion is early 2018 which will ensure full compliance to AS/4187. At present the CSSD has an action plan in place to address current compliance to AS/4187 and GENSA Guidelines. Improvements are to be congratulated.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

SSWPH has a raft of policies and protocols that address all aspects of medication usage and safety. The on-site Hospital Pharmacy provides clinical pharmacists for the assessment of high risk patients. There are a number of risks outlined which triggers a review by the pharmacist while the patient is an inpatient. Examples of this includes, any person aged 65 or over, multiple medication usage and type of procedure being admitted for. It is noted that the in-patient assessment by the on-site pharmacists indicated 90% of high risk patients were reviewed. The hospital has a very high admission rate for elective surgery procedures. The authorisation for medical use is monitored through AHPRA and this is checked regularly and updated at the time of yearly registration. A review of the RiskMan register revealed a culture of reporting and escalation within this reporting system. It is noted that the use of the Adverse Reaction Sticker compliance is less than 60% the hospital has recognised the results and will be continuing to monitor this area to increase compliance. There are audits noted whereby patients have been asked if they have been informed of potential side effects of medication and it is again suggested that this be a continuing focus to achieve a higher compliance.

Documentation of patient information

A review of a number of inpatient files, both active and inactive showed good documentation of medications. However, it is noted that more emphasis needs to be directed to the medication history of the patient. SSWPH are fully aware of this and there are ongoing audits and education to achieve higher results in the future. Arm band IDs are used to indicate a potential allergy or drug reaction.

Medication management processes

Medication management is well done. The storage and distribution of medications is pharmacy driven.

The use of the traffic light system for distribution is noted and gives certainty and governance to this process. MIMS is available on the wards as well as on the Intranet. Chemotherapeutic medications are dispensed on site and are mixed in a clean environment that requires gowning and gloving to access. The use of a treatment regime to limit hair loss through the purchase of a machine to cool the scalp while chemotherapeutic agents are being administered is to be congratulated.

S8 medications are documented in the correct legislated form. This includes any medications brought in by the patient. Disposal is also carried out in an accordance with policies and guidelines. The use of these drugs such as in theatre are signed out to each theatre and locked in dedicated cupboards within each theatre. There are locked draws in each of the rooms for the storage of patient medication. The keys are held by the nurse on duty. Impress cupboards on the wards are also locked and under the control of delegated nursing staff.

Continuity of medication management

Medication protocols are in place to ensure there is continuity. Further work needs to be done regarding medication reconciliation to ensure patients receive a comprehensive list of medications at the time of discharge, as well as the list of medications while an inpatient. The hospital is aware of this potential shortcoming and there are education processes and an action plan in place to address this. Perusal of the minutes of the Medical Advisory Committee (MAC) indicate also that the clinicians are aware of this.

Audits of the National Inpatient Medication Chart (NIMC) revealed shortcomings in the area of Patient ID on each page, Previous notification of an Adverse Reaction, VTE risk, and Medication History.

The hospital has an action plan in place and education has been provided. Ongoing audits since the annual NIMC audit show improvements in this regard.

Communicating with patients and carers

SSWPH have audited patient feedback that indicates that overall, patients have a good understanding of their medications. Further work regarding side effect notification when new medications are ordered and providing an up-to-date medication history to patients and medication management plan is underway.

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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

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STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Policies and procedures are in place that address all aspects of patient identification. Agreed bracelets are used for patient ID, alerts and allergies. The bracelets show at least three identifiers. The information label is printed rather than hand written. The Mental Health Unit has introduced a photo ID which is useful in tracing patients who leave the unit without notification. It is noted that the Maternity Unit as well as having the standard bracelet ID uses photo ID to identify the parents and this is done via the use of passport type photos when booking the admission for delivery. SSWPH is encouraged to investigate whether this technology would be useful in the ward setting.

Processes to transfer care

The peri-operative staff should be congratulated on the trial using a called patient ID transfer label. This is an excellent initiative as it allows seamless transfer from the ward to theatres and has reduced the chance of a miss transfer. It is noted that the trial is coming to an end and after review it is anticipated that this will become standard practice not only in the transfer from the wards to theatre but in other areas where patient transfer occurs. Surgical Time Out is well done, however the time out for the Anaesthetic Department is just over 50% and could be improved. The hospital is aware of this and steps are being taken through the Medical Advisory Committee to address the current compliance rate. The hospital is encouraged to continue to monitor the timeliness of discharge summaries to further enhance patients on going treatment.

Processes to match patients and their care

There is a suite of checklists and medical record forms that clearly identify the patients ID throughout their episode of care. Incidents are reported on RiskMan and regular audits are conducted. Results are tabled at the Quality and Risk Committee and benchmarked with Healthscope peer group hospitals.

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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

SSWPH conforms to all governance procedures required in clinical handover. There have been opportunities given to the surveyors to observe firsthand the handover from shift to shift, as well as from the holding bays in Theatre and from recovery to the wards. It is pleasing to note that the patients and their carers/relatives are actively encouraged to participate. There are no taped handovers and it is apparent that virtually all shift handovers are done at the bedside with active participation when required from the patients. The peri-operative staff have taken leadership in the time out surgical process and are auditing compliance regularly.

Clinical handover processes

Handover has been observed as noted above. Audit results show good compliance to the electronic faxing of discharge summaries by the nursing staff to the treating practitioner. The MAC minutes indicate there are some areas for improvement as a number of general practitioners would prefer an up-to-date discharge summary from the treating practitioner. The hospital and MAC are working closely to improve communication.

Patient and carer involvement in clinical handover

Patients and their carers are actively involved with their handover. This has been observed as mentioned at both the ward level and in the operating theatres. The surveyors took the opportunity to discuss handover with various patients and there appeared to be good interaction between patients, carers and staff.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

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

There are a number of corporate policies in place for the use of blood and blood products. Minutes of the Blood Transfusion Committee shows a very good appreciation of the use of blood and blood products. This committee meets monthly and reports to departments and craft groups. At the ward level, monthly meetings are held and minuted with action plans to address areas for improvement. Evidence was available to support the ACHS indicators as they apply to the use of blood and blood products. Audits have been carried out as recently as January and February of 2017 which show excellent compliance rates of 100% in Patient ID, safe collection of blood samples at the bedside and correct labelling of specimens. The hospital is working on improving compliance rates from the latest audit in regard to the correct labelling of donor packs on the IV orders and in the special observation chart, as well as the documentation of information given to the patient.

Documenting patient information

Improvements in documentation has been recognised and further education and audits are to be carried out. An audit in March 2015 showed 89% compliance was achieved in relation to the documentation of the patient's pre-history, which demonstrated an improvement it this area. To increase the compliance rate even further perhaps the pre-admission nurse can be encouraged to become more proactive in the medication history as it applies in Standard 4.

There is extensive literature including BloodSafe Consumer Information available in various languages which caters for the wide diverse ethnic population that the hospital caters to.

Managing blood and blood product safety

Blood and blood products are managed well. Evidence supported the system regarding 24-hour monitoring of the fridges where blood is stored. Audits indicated 100% compliance with all facets of temperature control and monitoring. Monthly meetings of the Transfusion Committee have storage and managing blood as standard items on their agenda. The hospital is not an acute trauma centre and as such their use of blood tends to be in elective surgery rather than as an emergency. However they do have a Massive Transfusion Protocol in place. Evidence of a recent elective procedure, a Nephrectomy led to excessive blood loss whereby the Massive Infusion Protocol was used.

There are processes in place to cater for any religious issues regarding transfusions.

Incidents are tabled at the monthly Transfusion Committee and escalated as required.

Wastage of blood and blood products is extremely low due to patient numbers and in the return of unused blood to the issuing authority.

Communicating with patients and carers

The catchment area for the hospital includes a wide ethnic population who are well provided with information in a number of languages. There is also the ability to contact interpreter services as required. Consent is incorporated in the surgical consent. Because of this it is problematical if sufficient information is provided regarding the potential complications and side effects of treatment.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

Inspection of the Oncology Day Centre revealed good adherence to informing patients even though the majority of their patients are overflow from the Liverpool Public hospital.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

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

The hospital has a well-documented Prevention and Pressure Injury Assessment Plan in place. Policies, procedures and assessment tools are used widely to ensure early detection and that the management of existing wounds is prioritised and intervention strategies are put in place if the need arises.

Staff education is conducted for all new staff and is ongoing.

Pressure injury equipment is readily available in all clinical departments. There has been no hospital acquired pressure injuries reported thus far which is to be congratulated.

Preventing pressure injuries

Significant work has been conducted relating to prevention protocols, identification, pressure injury point surveillance, risk assessment tools and equipment. Clinical staff are proactive and contribute to preventing wounds.

The hospital has also identified the need to include new born babies as part of their pressure injury prevention protocols. Well done. Theatre and day surgery are extremely conscious of there responsibilities in this regard.

Managing pressure injuries

Individual assessments and care pathways are designed specifically if the need arises. Wound charts are in place if a wound exists.

Pressure injury relieving air mattresses are used for all joint replacements as part of the preventative injury management plan.

Results are reported at the Standard 8 Cluster meetings and are included in Healthscopes Shared Learning's and used for staff education and training.

Communicating with patients and carers

Patients are provided with a raft of information by a multidisciplinary team of clinicians at the time of pre-admission through to discharge. If a patient is deemed "high risk" or has been admitted with a wound, they are certainly involved in their care plan and are provided with further education to help understand their role in pressure injury prevention.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

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

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The hospital is to be congratulated on their management of the deteriorating patient. A good deal of work has been conducted by the Intensive Care Unit (ICU) and clinical department managers to ensure robust systems are in place to recognise the deteriorating patient and newborn. Evidence-based tools are used which allows evaluation and auditing to be measured and compared in a systematic way. Clinical staff roles and responsibilities have been reviewed and disseminated to all staff. Emergency trolleys have been standardised to ensure staff have the most up-to-date equipment to undertake resuscitation safely and in a timely manner. New Zoll Defibulators have been purchased along with resuscitation mannequins for training of staff in Basic Life Support (BLS) Advanced Life Support (ALS) and Paediatric Life Support (PLS). The Rapid Response Committee reviews all MET calls and provides recommendations if needed.

Recognising clinical deterioration and escalating care

ISBAR is the communication tool used to report patient's deterioration. Track and Trigger adult and Paediatric observation charts are in place as well as a newborn care flow chart to alert and flag deterioration.

Staff feedback is positive and they feel confident when making a MET call.

Responding to clinical deterioration

The establishment of the Rapid Response Team (RRT) has clearly improved the management of the deteriorating patient. Staff are aware of their responsibilities and there has been a significant focus on education and training.

The surveyors were very impressed with two projects undertaken in regard to this Standard.

Project one Triggering a call for emergency Assistance has been awarded a MM for the outcome of a trail of an ATOM TRANSCAPSULE in Maternity Services - Refer to comments in Action 9.5.1.

Project two ALS/ARC clinical staff training has been awarded a MM for the hospitals good work - Refer to comments in Action 9.6.1.

Communicating with patients and carers

There are well established systems in place to ensure patients are informed regarding their care needs if an adverse event or deterioration in their health occurs.

The REACH program is well established, patient rounding is conducted, clinical handover, how to escalate a response to care concerns and the daily case conferences conducted in ICU with patient's families and clinicians are managed well.

There has also been some very good work in relation to End of Life, Advanced Care Planning and Not for Resuscitation. This information is highlighted at the time of admission and is critical in responding to any patient's deterioration.

Doctors, staff and manages are well supported and educated in this area and if the need arises staff can access the Employee Assistance Program and for relatives bereavement counselling is also available. The need has not arisen thus far.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

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	MM
9.5.2	SM	SM
9.6.1	SM	MM
9.6.2	SM	SM

Action 9.5.1 Core

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

Surveyor Comment:

The trail of ATOM TRANSCAPSULE in Maternity Services

In February, this year a routine service of the ATOM Transcapsule uncovered a crack in the capsule. The Neonatologists were informed and suggested an alternative method of transporting the newborn from theatre to the post natal ward. This lead to a trial of a new model. In the meantime however, it was identified by the hospital that the transport arrangements with NSW Ambulance for a sick baby was still a high risk and the purchase of a new capsule for the hospital would not solve the problem in that NSW Ambulance had only one of these capsules which was kept at a station some distance from SSWPH and other health services in the area. If there was a need for a sick baby to be transferred it could take up to 4-6 hours for the ambulance to arrive, as they needed to pick up the cot and then attend to the call from the hospital. The hospital took the initiative to invite NSW Ambulance to a meeting and demonstration of the new capsule to ascertain whether it would be compatible with their vehicle needs for transportation. The answer was yes. The hospital proceeded with the purchase of the new ATOM Transcapsule.

The outcome is that the delay in waiting times has significantly reduced.

SSWPH is the only Healthscope hospital in Sydney to provide this equipment. Other health facilities such as, Nepean and Blacktown Public can also utilise the capsule as well.

The surveyors were extremely impressed with the hospitals proactive approach and their commitment to patient safety.

A Met with Merit (MM) has been awarded for this significant achievement.

Surveyor's Recommendation:

No recommendation

Action 9.6.1 Core

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

Surveyor Comment:

A project was identified in regard to ALS/ARC training

The proposal was initiated by the ICU and based on the hospitals ability to not only provide BLS training across the hospital, but to enable ALS training to be available to staff on site through their own educators. The solution put forward was to establish and conduct ALS Courses through the Australian Resuscitation Council (ARC). The course would cater for not only staff at SSWPH but would also open up opportunities for health care clinicians at other health services in the area to have access to the course at a discounted rate.

The submission was supported by SSWPH ICU Director and team of medical staff who would conduct the ARC accredited course. Equipment and recourses were sought through Healthscope and proceeds from the first number of courses would be used to purchase necessary equipment to conduct future courses.

ALS Provider Course Regulations were reviewed and the course content and registration requirements ratified.

The course commenced in October 2016. Seven internal applicants were received, as well as five staff from external hospitals in the Heallthscope group and one from Liverpool Public.

The evaluation results were highly impressive and participants rated the course as excellent. The next course will be offered later this year.

The surveyors were extremely impressed with the hospitals commitment to education and training in this regard.

A Met with Merit (MM) has been awarded for this achievement.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

The hospital manages falls well. Policies, procedures and best practice guidelines are embedded in every day practice.

Staff education forms part of the training schedule. Staff are aware of their responsibilities to ensure falls are minimised. Falls analysis/trends summaries, as well as the results from audits and incidents are reported to the Safety and Quality Committee. Departments are actively involved in falls prevention and the management of falls.

Screening and assessing risks of falls and harm from falling

There is a suite of risk assessment tools used which provide a very systematic and standard approach to the identification and management of falls.

Falls risk assessments are conducted at pre-admission and if a patient is deemed at risk a comprehensive management plan is put in place. Very few falls have been reported which is to be congratulated.

Preventing falls and harm from falling

There is a multidisciplinary team approach to falls and all clinicians are engaged and extremely proactive in this regard.

Patient rounding, clinical handover and fall minimisation plans all form part of a comprehensive toolkit to falls management and prevention.

Equipment and patient aides are readily available if required.

Communicating with patients and carers

The hospital has continued to acknowledge patients that may be at risk of falling. At the time of admission patients are screened and are provided with a wealth of information if the need arises. Grip sox and alerts such as, the Catch a Falling Star are used when required.

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

NSQHSS Survey

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Sydney Southwest Private Hospital
Orgcode: 120303

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

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

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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Documentation of patient information

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

Medication management processes

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

Continuity of medication management

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

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

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

Documenting patient information

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

Managing blood and blood product safety

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

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Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

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

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

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

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

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Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

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Recommendations from Previous Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Governance and systems for infection prevention, control and surveillance
Action: 3.1.4 Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols

Recommendation: PR+ NS 0312.1.5.2#2

Recommendation:

A dedicated space be made available to clean, process and store endoscopes; and that the current and future demand for endoscopes be assessed and provided for.

Action:

PROGRESS REPORT RESPONSE June 2015

The alternative plan as detailed below was to utilize the unused wash up area adjacent to CSSD. This plan was approved by HICMR upon the condition that structural alterations occurred to facilitate this.

These included the demolition of one wall.

Upon further discussion with our Facilities Manager it was identified that we were unable demolish this wall as it was a load bearing and fire wall.

GM and State Manager are currently in the final stages of negotiating funding with Healthscope Corporate for major building works. If approved this will provide additional theatres and ward areas. DA approval is current and Architects have been commissioned. It is envisaged that plans will be drawn second half 2015. A purpose built endoscopic processing area will be an inclusion in these plans, and will therefore address this recommendation to conclusion.

The most recent compliance audit for Endoscopy was performed by HICMR 28/10/14 Compliance was 93%

Action:

Expert advice has been sought from HICMR. An area for the processing of scopes has been identified between theatres 4 and 5.theatres.

A planning was meeting held 22.08.13:

- Architects are to be engaged to draw a floor plan for Endoscopy between theatres 4 and 5.

- HICMR to provide advice on the floor plan once received from the Architects

HICMR reviewed the above plan, it was deemed not suitable due to the positioning of the scope washing sinks.

An alternative plan was developed utilizing the unused wash up area adjacent to CSSD.

This plan was submitted to HICMR who advised suggestions for minor alterations required

The GM advised of above which would involve the demolition of one wall. The GM will continue the discussion with the architetects

- HICMR to provide advice on the suitability of the scope storage cupboard and the sterile stock cupboard during the above process.

Endoscope Demand

As at October 2013, the hospital has 15 adult endoscopes available for use, and 1 paediatric.

There have been endoscopic procedures in the past 12 months in the hospital. Endoscope lists range from 1 to 20 patients per list this is operator dependent. The endoscopy processing area is staffed according to patient volume.

Each endoscope takes approximately 15-30 minutes to reprocess and be made available for use

The most recent scope audit conducted by HICMR was Flexible Endoscopes.

This audit was done on the 24th July 2013.

There were thirteen recommendations from the report.

Most of the recommendations are environmental issues.

Compliance was 95%.

The Assessors general comment is that the Endoscopyunit needs to be relocated. A possible area for same has been identified and the facility executive is supportive of this relocation. A significant number of the recommendations in the report will be addressed if the upgrade goes ahead.

Next audit due in twelve months.

There is a process in place to obtain loan scopes from Olympus in the event that a scope requires servicing or repair.

There is a CAPEX process in place to obtain funding if the replacement of a scope is required.

Completion Due By:

Responsibility:

Organisation Completed: No

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Surveyor's Comments: Recomm. Closed: No

Plans are in place to renovate the area so that the processing area can be moved into an enclosed room. This will improve the workflow and storage arrangements. The solution is not ideal but will be a big improvement on the current situation. It is planned for this work to be completed by the end of 2014, and therefore should be followed up next survey.

The recommendation is ongoing.

SELF ASSESSMENT RESPONSE June 2015

The alternative plan as detailed above was to utilize the unused wash up area adjacent to CSSD. This plan was approved by HICMR upon the condition that structural alterations occurred to facilitate this.

These included the demolition of one wall.

Upon further discussion with our Facilities Manager it was identified that we were unable demolish this wall as it was a load bearing and fire wall.

GM and State Manager are currently in the final stages of negotiating funding with Healthscope Corporate for major building works. If approved this will provide additional theatres and ward areas. DA approval is current and Architects have been commissioned. It is envisaged that plans will be drawn second half 2015. A purpose built endoscopic processing area will be an inclusion in these plans, and will therefore address this recommendation to conclusion.

Self-Assessment Response September 2016

To meet the recommendation:

Approval and commencement of two new operating theatres and CSSD have begun.

A purpose built endoscopic cleaning/processing area has been included into the architectural plans.

Therefore, the recommendation and action will be complete at the commissioning/opening of the new build.

This is expected to be early 2018.

Completion Due By:

Responsibility:

Organisation Completed: No

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

The hospital has undertaken a considerable amount of work and capital investment to address this recommendation. The Healthscope Board approved a redevelopment for Sydney South West Private Hospital (SSWPH) which includes a new CSSD.

The building has commenced and is anticipated to be completed early 2018. In the meantime, the hospital has risk rated their current processes, segregated the cleaning and disinfection of scopes, purchased a drying and storage cabinet, as well as new scopes. Auditing and education is ongoing.

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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**

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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**

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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: Sydney Southwest Private Hospital
Orgcode: 120303

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	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	13	2	15
Standard 10	18	0	18
Total	**207**	**2**	**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: Sydney Southwest Private Hospital
Orgcode: 120303

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	21	2	23	Met
Standard 10	20	0	20	Met
Total	**254**	**2**	**256**	**Met**