Assessment Report

Gold Coast Private Hospital Pty Ltd

Assessment dates	19/07/2018 to 23/07/2018 (Please refer to Appendix for details)
Assessment Location(s)	Southport (000)
Report Author	Jane McGarry
Assessment Standard(s)	ISO 9001:2015

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Executive Summary

Continued certification to ISO 9001:2015 is recommended following the continuing assessment visit on 18 – 19 July 2018. The Gold Coast Private Hospital has been found in general compliance with the audit criteria as stated in the audit plan.

The documented Quality Management System for Gold Coast Private Hospital (GCPH) describes integrated systems of corporate and clinical governance to actively manage patient safety and quality risks that include delivering high standard of individualistic quality patient support that is reflected in both interactions with people and processes to ensure a safe and efficient health service

The scope of the quality management system is structured to the requirements of ISO 9001:2015 as well as the National Safety and Quality Health Service Standards 2012 and has been designed to support the Strategic Direction and ensure the GCPH remains responsive to customer and stakeholder needs and feedback in the dynamic market that is Private Healthcare to deliver intended results.

The strategic direction of Gold Coast Private Hospital (GCPH) is detailed in the Strategic Plan, Hospital Safety and Quality Plan, Clinical Governance Framework and Quality Manual. There are now four strategic pillars and organisational goals that outline and form the foundation of the Hospital strategic plan, together with GCPH Vision and Credo "Our family caring for your family - for life" which is evident at all levels within the organisation.

The four strategic pillars include Quality Clinical Outcome; Exceptional Patient Care; Creating Extraordinary teams; and Delivering market leading financial returns. The plan outlines the goals required to be met by the Executive team (Top Management) to measure success and meeting patient safety objectives and intended results of the QMS. These goals are cascaded from the Hospital Executive Management to the GCPH Heads of departments with identifiable and measurable targets for the relevant departments and evident that these are monitored through monthly Round Table meetings between department managers and the executive team.

It is evident the strong and enthusiastic leadership of the Executive team continues to foster a positive culture within the hospital which is reflected in the strong team spirit, innovation and sense of pride that was demonstrated on many of the wards and departments visited during the onsite survey in particular established innovative projects initiated by GCPH.

These innovations include "CPR for kids" providing 1 – 2 sessions per month with overwhelming response has demonstrated the hospital is the 'point of difference' in the community by the unique specialised services provided.
Other innovations include The Food Services team awarded the Healthscope 2017 STAR Food Services Team National Best Team- Aspiration with the GCPH hospitality manager currently leading the Healthscope Standardizing Food Service Project 2018 across Australia.

There were no findings or opportunities for improvement identified during the assessment. Enhanced detail relating to the overall assessment findings is contained within the subsequent section of the report.

Changes in the organization since last assessment

There is no significant change of the organization structure and key personnel involved in the audited management system.

No change in relation to the audited organization's activities, products or services covered by the scope of certification was identified.

There was no change to the reference or normative documents which is related to the scope of certification.

NCR summary graphs

There have been no NCRs raised.

Your next steps

NCR close out process

There were no outstanding nonconformities to review from previous assessments.
No new nonconformities were identified during the assessment. Enhanced detail relating to the overall assessment findings is contained within subsequent sections of the report.

Please refer to Assessment Conclusion and Recommendation section for the required submission and the defined timeline.

Assessment objective, scope and criteria

The objective of the assessment was to conduct a surveillance assessment and look for positive evidence to ensure that elements of the scope of certification and the requirements of the management standard are effectively addressed by the organisation's management system and that the system is demonstrating the ability to support the achievement of statutory, regulatory and contractual requirements and the organisation's specified objectives, as applicable with regard to the scope of the management standard, and to confirm the on-going achievement and applicability of the forward strategic plan and where applicable to identify potential areas for improvement of the management system.

The scope of the assessment is the documented management system with relation to the requirements of ISO 9001:2015 and the defined assessment plan provided in terms of locations and areas of the system and organisation to be assessed.

ISO 9001:2015
Gold Coast Private Hospital management system documentation

Assessment Participants

Name	Position	Opening Meeting	Closing Meeting	Interviewed (processes)
David Harper	General Manager	X	X	X
Claire Gauci	Deputy General Manager	X	X	X
Debra Billington	Director of Nursing	X	X	X
Suzanne Callaway	National Quality Improvement Manager - Healthscope Ltd, Hospitals	X	X	X
Linda Sawrey	Quality Manager	X	X	X
John O'Shea	Hospitality Manager	X	X	X
Julian Porter	Accounts Manager	X	X	X
Anne-Marie Buhmann	Peri-operative manager		X	X
Helen Clarke	CSD Manager		X	X
Kelly Harland	Infection Control Officer		X	X
Zobaida Moradi	NUM ICU		X	X
John Dalziel	Chief Pharmacist		X	X
Stuart Thompson Coleman	NUM Emergency Care Centre		X	X
Jenny O'Keefe	NUM Ward 1		X	X
Christine Smith	NUM Ward 12		X	X
Bevyn Carr	Facilities Manager		X	X
Shanyn Fox	Facility Contract Coordinator - Maintenance		X	X
Din Turong	Biomedical Engineer		X	X
Jackie Humphry	Food Services		X	X
Lucy Danaher	Service Improvement Officer		X	X
Anne Marie Buhmann	Perioperative services manager		X	
Sarah Galton	Service Improvement Officer		X	X
Eileen Kearns	Service Improvement & EEN		X	X

Nicole Abercrombie	Service Improvement Officer		X	X
Courtney Dickson	Education Admin Officer		X	X
Brook Atkins				X
Rhonda Bevan	Consumer Representative			X
Dr Andrew Jones	MAC Chairman			X
Melito Bulan	CSD staff member			X
Nadine Smith	Health Information Manager		X	X
Anna Arden	Rehabilitation and Allied Health Manager		X	X
Celeste Hearne	Rehabilitation NUM		X	X
Judy Ross	Maternity		X	X
Jodi Ma Jong	Workplace Safety Manager		X	X
Emma Childs	Executive PA		X	X
Lydia	Credentialing coordinator		X	X
Emma Gerrard			X	X
Joyce Percy	Housekeeping supervisor		X	X
Tanya Ray			X	X
Jacinta Forge Jones	Surgical Ward		X	X
Mandy Cook	Surgical Ward		X	X
Hazel Douglas	NUM DOSA		X	X
Gareth Freeman	Anaesthetic Assistant NUM		X	X
Anne Marie Walsh			X	X

Assessment conclusion

BSI assessment team

Name	Position
Lynette Dasey	Team Member
Jane McGarry	Team Leader

Assessment conclusion and recommendation

The audit objectives have been achieved and the certificate scope remains appropriate. The audit team concludes based on the results of this audit that the organization does fulfil the standards and audit criteria identified within the audit report and it is deemed that the management system continues to achieve its intended outcomes.

RECOMMENDED - The audited organization can be recommended for certification / recertification / continued certification to the above listed standards and has been found in general compliance with the audit criteria as stated in the above-mentioned audit plan.

Use of certification documents, mark / logo or report

The use of the BSI certification documents and mark / logo is effectively controlled.

Findings from this assessment

ISO 9001:2015 LEADERSHIP AND COMMITTMENT CLAUSE 5 & 9.3:

The following process, documents and/or records were reviewed

- **Quality Management System** (QMS) is detailed in the Gold Coast Private Hospital (GCPH) Quality Manual (v3 July 2018) and outlines how the hospital ensures quality is consistently achieved through the ISO 9001:2015 and NSQHS 2012 standards.
- The QMS is described in the GCPH Safety and Quality and Strategic Plan (2018 – 2022) and Quality Manual as well as related policies and processes and includes the quality policy and objectives, and compatible with the strategic direction takin the responsibility to promote risk based thinking, customer focus and improvement.
- Four strategic pillars are described in the Strategic Plan: – Quality clinical outcomes; Exceptional patient care; Creating extraordinary teams and Delivering market leading financial returns.
- Each of the four strategic pillars has a goal descriptive with actions, responsibility, timing, progress and outcome, KPI, Saving /cost per annum.
- The goals are cascaded from the hospital executive management to the GCPH heads of departments with identifiable and measurable targets for their departments.
- General Manager and the Executive team are involved and committed to assessing the quality management system's effectiveness through monthly round table accountability meetings held between executive representative and managers as one example of Leadership commitment.
- Monthly Round table Report viewed for the Perioperative Department (PARU, Anaesthetics, Theatre and DOSA) June 2018 that details achievement of targets and action plans to achieve and measure quality outcomes.
- Documented quality policy (vision) details the hospitals service improvement commitment to key focus on patient safety, customer satisfaction and continuous improvement. The policy sets the framework for setting quality objectives.
- Implementation of the Qualtrics system – A patient Experience Survey which is a live system that enables action on any positive or negative comments by patient which are immediately followed up by the relevant manager. The survey is sent electronically to all admitted patients of the hospital with the patient agreement to participate with option to decline. The Gold Coast Private Hospital has had 1648 responses from January 2018 to present with increase from 123 (81%) in January 2018 to 216 (88%) responses from 1/7/18 – 18/7/18.
- Net Promotor Score (NPS) is equivalent to a top score of 10/10. GCPH currently sits at 85.7%. The Net promotor Score for 1/7/18 – 18/1/18 (244 responses) compared with Net Promotor score for July – September 2017 = 78%.
- GCPH has increased the NPS for each quarter from 78% & 81% in 2017 to 83% & 85.7% 2018 compared to the KPI target for Net Promotor Score for all Healthscope facilities as greater than 50%. GCPH leads their Peer one group of Healthscope hospitals.
- **Roles, Responsibility and Authority** is communicated by the Hospital Executive to all stakeholders including staff responsibility for participation and continual quality
- improvement within the hospital through staff meetings, internal meetings, staff Safety, Quality and Education communication boards. Same sighted in staff dining room 18/7/18
- Quality Management System responsibilities are included in position descriptions, performance reviews, mandatory education and competency records, education calendar and Strategic Plan

- **Management Review** – Inputs and Outputs is managed through hospital executive meetings for 2/7/18; 25/1/18 and 16/4/18. Medical Advisory Committee meets three monthly minutes Clinical review meetings 14/5/18 held quarterly committee reports from all clinical craft groups reporting on clinical risk/feedback, risk register, shared learning, national standards and complaints. WPHS meeting 11/6/18. Reports of significance from these committees are provided to Executive management meeting.
- Morbidity & Mortality Review occurs monthly e. g. 23/4/2018
- Clinical practice meetings attended by director of nursing and nursing unit managers from all departments sighted 8/2/18 12/4/18; 14/6/18

Planned activities/intended results have been achieved

CONTEXT AND SCOPE OF MANAGEMENT SYSTEM ACTIVITIES - CL 4:

- The following process, documents and/or records were reviewed.

  External and internal issues are identified in the Hospital Strategic Plan, GCPH Safety & Quality Plan, GCPH Quality Manal, WHS Infection control and Marketing Plan, Riskman Register, monthly department meetings, Quality Mortality and Morbidity Meetings and Review Marketing Plan.
- **Monitoring and review of internal and external issues** is detailed in the Safety and Quality Plan, Quality Manual and Strategic Planning process.
- **Quality management system and its processes** is detailed in the patient process map which includes patient admission, assessment, intervention, care delivery, discharge and post discharge contact. Each section details the process interactions associated for each. Form S1-005 V2 June 2018.
- **Needs and expectations of interested parties** include consumers, families and carer, staff, accredited healthcare professionals, contractors and suppliers, service providers, e.g. Pathology, Medical imaging, pharmacy, radiation oncology and General Practitioners.
- **Scope of the management system** is the provision of Acute Care, Emergency Department 24 hours, Intensive Care Unit, Cardiac and Thoracic Surgery, Coronary Care Unit, Cardiac Catheterization, Children's surgery, ENT, Gastroenterology, General Surgery, General Medicine, Medical Oncology, Gynaecology, Urology, Orthopaedics, Plastic and reconstructive Surgery, Rehabilitation, Renal Medicine, Children's medicine, Hospital in the Home, Respiratory Medicine, Maternity, special care and birthing suites. Hotel services and education and training, administration, operational infrastructure

Planned activities/intended results have been achieved

PLANNING, RISK, OPPORTUNITIES AND THEIR MANAGEMENT CL 6.1-6.3:

The following process, documents and/or records were reviewed

- Risk identification and management is incorporated in to the quality management system planning processes that ensure an integrated approach to risk management.
- Risk register is Riskman and review of the risks depends on the level of risk.
- Risk register identifies potential risks for non- clinical and clinical areas.
- Sighted risk #17470 due for review of effectiveness of actions to manage identified risk on 23/7/18.
- Risk # 17597 involving response to emergency procedure codes. MET calls and codes – ICU attend both.
- Riskman incidents #1523599; 1534696; # 1534696 viewed and no adverse outcome reported Riskman # 1525275 – near miss.
- Paediatric emergency response – Emergency doctor attends automatically.
- After-Hours coordinator enters codes in Riskman.
- Identified risks are collated on the Risk Register. Reviews of risks are monitored by internal audits, internal and external reviews.
- Actions to address Risks and Opportunities related to **Quality Objectives** contained in Strategic Plan and Clinical Governance Framework.
- Risk Management and Integrated Risk Register policy 1.34; Risk Management – Clinical No. 1.38**;** Risk Management system – Use of Riskman

  Planned activities/intended results have been achieved

RESOURCES, INFRASTRUCTURE AND CONTROL OF MONITORING AND MEASURING EQUIPMENT/MEASUREMENT TRACEABILITY, EXTERNALLY PROVIDED PROCESSES, PRODUCTS AND SERVICES (PROCUREMENT, SUBCONTRACTOR MANAGEMENT) - CLAUSE 7.1.3, 7, 7.5.2. 8.4:

Facilities Management is responsible for all infrastructure services (including IT) and the Biomedical and Maintenance departments. The Coordinator plays a pivotal role across the department in organising and controlling the work flow. The GE Healthcare AssetPlus management (including Asset Register) is applied and includes a preventative maintenance schedule that is priority rated 1-14. Measuring equipment used in the maintenance/calibration of biomedical equipment is now calibrated in house by certified biomedical engineers. A shared services agreement between GCPH and Queensland Health for the provision of utilities is in place. It highlights performance requirements and includes op-outs for poor performance. This includes contingency supply of services such as emergency power, water, and air conditioning considered essential services and therefore high risk.

The following processes and documents were reviewed

- An approved service provider list is in place that includes all sub-contractors

- Contract management controls are applied using "Who's on Location" software via web browser. It tracks contractor profiles to ensure licenses, insurances, qualifications and other are current and alerts expiry dates. Contractor performance evaluation occurs bi monthly
  e. g. audit of service reports posts completed work 25/5/2018 # IV
- IT services are negotiated and controlled by Corporate services. A regional IT specialist attends on site visits weekly and there is a corporate "Help Desk". The Coordinator also provides on-site support.
- All staff are also required to complete the Healthscope "8 Steps to Cyber Security" training
- Air Conditioning Contracts are applied via a tender process as compliant with Healthscope Policy 6.11 2016 and controlled locally. Currently a pre-selection checklist is being trialled
- Work Instruction W118" Contractor Management Pre-selection Service Provider Equipment Service Request Form" is in place
- Plant Hazard Audit 27/5/2018 Chemical & Plant Room>satisfactory results
- Certificate of Analysis for Legionella Symbio Laboratories 12/6/2017 & 28/6/2018
- Fire & Safety- Johnson Controls 31/1/2018 applied monthly, 6 monthly & annually
- Stokes Safety Essential Safety Measures 8/12/2017 & 1/2/2018 Fire Safety & Air Conditioning
- "Emergency & Business Contingency" 5/4/2017 reviewed annually and as required e.g. additional wards & theatres review due 2018
- Reactive & preventative maintenance training by GE Healthcare for all department staff. Samples include GE Certificate AISYS Frontline Anaesthetic Machine 1/9/2016 # DT 19/6/2018 # BT
- GE Carlscape Monitors & Modules Training Certificate # BT 22/6/2018
- #DE Calibration Certification Digital Thermometers 18/7/2018, Patient Scales 16/7/2018, Blood Fridge 16/3/2018, PROSIM 8 15/3/2018
- A Procurement process described by the Coordinator and Product Evaluation Group pre-purchase of goods is in place
- Healthscope 15-001 Acceptance & Commissioning policy & procedure & W591 Acceptance & Commissioning of Equipment
- GCPH W357 & W353 Supply Team Receiving and Delivery of Goods

Planned activities/intended results have been achieved

OPERATIONAL PLANNING AND CONTROL - CLAUSE 8 - PERIOPERATIVE SERVICES :

- The following process, documents and/or records were reviewed

  Review of Perioperative Services – Commissioning of new theatres currently in progress.
- Compliance Certification Certificate issued 22/6/18 for Day Surgery theatres 1 & 2 and Procedure rooms 1 & 2; Level 1 theatres 14 & 15 and 16 & 17.
- Private Health Facility Licence for GCPH for 314 total beds including 14 Cardiac (Coronary) Care Beds, 12 Intensive Care Beds, 9 Neonatal Special cots. Issued 25/5/2018 expiry date 30/9/2020.
- Air sampling completed in new theatres, cleans completed hope to open 6/8/17 depending on culture of hepa filters.
- **Total of 17 operating theatres on line by 6/8/18**

- **Perioperative Suite –** compliance with statutory & regulatory requirements. Each theatre has own S8 DD Register and checked daily by team leaders
- Calibration conducted by on site biomedical department through Asset Plus
- Perioperative Services Meeting held 18/7/18
- Compliments and complaints (1 May) and (2 June)
- Follow-up calls April – June = 2
- Perioperative Riskman – report tabled for April, May June 2018
- Hand hygiene results – GCPH = 85%; Theatre total = 141/159 moments = 88%
- VMO = 84%; Nurses 91%; Ward services = 71%
- ANT skills assessment = 90% June; Bedside Handover skills assessment = 89% June; BSL skills assessment = 100% June 2018; Manual Handling skills assessment = 85% June 2018.
- **Education summary** sighted – perioperative unit for June 2018 show a total of 16 sessions provided with 149 attendees
- **Incident management- clinical incidents** – perioperative department 1 July 2017 to 30/6/18 presented in the Round Table Report – Perioperative services in the following categories: Infection prevention/control = 15; Patient ID/Matching =33; Medication safety = 42; Clinical Handover = 4; Blood/Blood Product= 2; Preventing /Managing Pressure Injuries = 12; R & R Clinical Deterioration = 87; Falls =1
- Sighted Massive Blood Transfusion Protocol. Is accessible on line and displayed on anaesthetic trolleys in each operating theatre. Anaesthetist activates MBT. Flow charts indicate staff and QML roles
- Daily Checking Paeds emergency trolley, Resus trolley – top of trolley only. Full checks of trolley monthly; difficult intubation x 2 trolleys close to recovery,
- Malignant Hypothermia trolley checked daily.,
- Biomedical engineering checks OT
- Three OT educators work 24 hrs each Monday – Friday – Educator allocation to recovery, anaesthetic and scrub scout.
- Management sighted June 2018- Strategic pillars of governance, riskman reports, feedback to staff. Risk man reports feed into round table monthly meetings with Executive and Peri-operative committee and anaesthetist meetings.
- ANSafe meeting group – M&M – all anaesthetists from Gold Coast University Hospital and GCPH meet. Peri-operative managers from respective facilities present reports.
- **Patient admission from Day of Surgery Admission (DOSA)** reviewed UR # 728514 & # 520745 all forms completed, anaesthetic check by nurses, surgical safety check list
- Patient identification policy – Work process No. WO 18 V 3 Jan 2018,
- Healthscope Policy 2.08 Patient ID Policy – Sept 2017. Admission of Patient to Acute Medical / Surgical Hospital No. 8.11
- Alerts – documentation and Management – W-109
- Communication policy – Chain of Command policy 2.19
- Noted red alert notices placed on patient records indicating patient same name alert. Red alert notices also indicated if consent for operation absent. Patients do not proceed until treating doctor completes consent form.
- E-admission encouraged and has improved over the 3 year period of the hospital operating from 0 – 49%.
- Management of Patient Belongings - process observed. Blue hospital bag used with zip ties and tagged with patient identification sticker. Entry in sign in and out book. Form OT-002 /

perioperative services admission centre sign in sign out register used. Sighted UR # 727013, Box 8 & 9 contained patient belongings – checked name on both items with zip tied.

Planned activities/intended results have been achieved

OPERATIONAL PLANNING & CONTROL - CLAUSE 8 CENTRAL STERILE DEPARTMENT:

- The following process, documents and/or records were reviewed

  CSD has 7 sterilizers including Sterrad, 100NX Low temp sterilizer used for cameras, fibre optics, and scopes.
- New loading and unloading trolleys recently available – staff training provided by InVitro (suppliers of Sterilizers).
- **Tracking processes** - TRAYBAX - is a whole track system for instruments. Observation of process conducted by CSD new staff member for UR # 728318 – details instruments used for the case; UR # 725884 – Lap case and UR #7288316,
- **Traceability** - Twenty four hour report on 17/7/18 for 5 patients #723511; 728313; 721413; 728366 and 541779. Tracking sheets scanned each morning and saved in L drive.
- Dosing system to be installed for all chemicals used in CSD.
- Sighted cycle No. 05278 from No 3 washer indicated cycle complete and OK.
- **All 25 staff completed basic CSD competency** and Steelco washing competency.
- **AS/4187 quality action plan** sighted, ongoing progress noted.
- Invitro washers and sterilisers have annual service agreements – maintenance for sterilisers.
- Sterrads – Johnson and Johnson service agreement and SESS – Dragon Low Temp sterilizer
- 100NX and 100 Sterrad validation completed 2018. Three new sterilisers completed awaiting certificates.
- OT Cleaners only and clean theatres at night.
- CSD daily soil test on all machines daily; Daily cleaning tasks AM & PM noted and signed. Weekly clean schedule and cleaning Sterrad & sterilizers check list signed. Monthly Protein Testing completed June 2018.
- Incidents reported to Peri-operative manager for monthly round table. Round table reports presented at monthly meetings
- Safety data sheets sighted and all SDS sheets reflect chemicals held in the department.
- CSD cleaning policy No 07-010 "Cleaning Disinfectant & Sterilising
- Sterile Consumable Storage Policy 13-025
- Incident Management Policy No 2.13; Sentinel Event Management 1.35
- Communication – Internal Policy no. 4.43.

Planned activities/intended results have been achieved

OPERATIONAL PLANNING AND CONTROL - CLAUSE 8 - INTENSIVE CARE UNIT (ICU):

The following process, documents and/or records were reviewed

Patient Journey Admission to internal/ external transfer;
The NUM (internal appointment since the previous audit) described the end to end process providing examples along the stages of patient care. These included but not exclusive to;
Documentation and sampling of patient management process;

- #123255, #367615, #515155, #534858, #254681, #537003
- Controls are in place to ensure that all patient records are checked for compliance to policy in ICU by the Clerk prior to receipt by the medical records staff who audit and return for completion if any omissions arise prior to completion of coding
- All patients are reviewed by the ICU medical staff and VMO on admission, throughout the treatment period and on transfer

Case Management Review;

- Case review is identified and completed quarterly by the DCS, NUM, VMO & ICU VMO as identified in #123255, #367615, #515155, #534858, #254681, #537003 and issues to be actioned are reported at the Clinical Review meeting quarterly
- Morbidity & Mortality Review occurs monthly e. g. 23/4/2018

Incident Management;

- Riskman system is applied and priority rated as is the Risk Register
- #1537797 30/5/2018 Clinical Handover-failure to inform the VMO of patient results (verbal handover)>action plan – VMO to sign results reviewed or if by phone 2 RN's to sign. Audit 24/7/2018 100% compliance
- Incident reporting is included in the NUM Round table reporting June 2018 and referred to the Clinical Review meeting quarterly and the MAC as appropriate

Patient Identification;

- Compliance with Patient ID & Handover policies & procedures
- #537003 16/7/2018 post-operative admission, ICC Flow Chart-comprehensive and signed to date, includes SBAR and patients/family, bed board information in situ
- Treatment plans are reviewed and signed 4 times in 24 hours

Patient Communication and Feedback;

- All patients are reviewed post operatively by the VMO and family contacted
- All staff in ICU receive, report and action feedback on a shift by shift basis from patients, family and carers
- Patients are encouraged to give feedback on the Qualtrics Live e-system on discharge that has seen a much greater level of consumer participation and subsequent actions completed. A paper system remains in place for those unable to access or utilise the e-system
- Complaints are actioned as per the Complaints Policy and are included in the NUM Round table reporting June 2018 and referred to the Clinical Review meeting quarterly and the MAC as appropriate

Patient Transfer;

- Internal Transfer Form MR4.95 T is applied as per the ISBAR method #718750 18/7/2018 ICU to Ward
- Inter-Hospital Transfer may occur with ambulance escort as per #258928 15/9/2018 to John Flynn Hospital
- A CQI was implemented to communicate with the patient GP on transfer/discharge

Miscellaneous;

- A Nurse Educator is employed to service ICU and ECC
- The WH&S representative attends monthly meetings & reports hazards monthly

- Intubation Trolley checked monthly to date July 2018
- Drug Trolley checked daily to date July 1-18, 2018

Planned activities/intended results have been achieved

OPERATIONAL PLANNING AND CONTROL - CLAUSE 8 - EMERGENCY CARE CENTRE:

The following process, documents and/or records were reviewed

Patient admission by ambulance witnessed by auditor

- Documentation management process; Patient identification and Patient Communication and Feedback were evident and in practice for patient # 225732 Bed 5 ECC. Para medic verbal handover and formal documentation for patient with chest pain and multiple co morbidities. SBAR method applied by NUM. Patient known to staff and communicated effectively with the NUM & Registrar and treatment commenced without delay. The Ward Clerk accessed patient details on Webpas and identified an alert was in place with multiple previous admissions. The patient record was compiled, and ID applied within 30 minutes
- Patient assessment includes wounds /pressure injury to identify pre-admission non-hospital acquired injury. In June 2018 this applied to 6 admissions. A plan of care is developed with the patient/family as per #1560750
- Internal transfer processes between ECC & ICU are in place and accessible to all staff as demonstrated in ICU and confirmed by the ECC NUM. The Nurse Educator also services both areas that ensures effective communication for education purposes.
- Patients transferred/discharged from ECC are followed up by phone by an RN as identified 17/7/2018 4 patients
- A Service Improvement Work Process Register (by area) was in place e. g. GCPH Transfer Patient Post Met Call & Transfer of Patient Inter Hospital
- The ECC NUM participates on the Disaster Management District Committee. This included the recent Commonwealth Games Plan.
- Emergency Trolley daily check July 1-18, 2018 completed

Planned activities/intended results have been achieved

CONTROL OF EXTERNALLY PROVIDED PRODUCTS AND SERVICES - CLAUSE 8 - PHARMACY & WARD 1 :

The following process, documents and/or records were reviewed

The HPS Pharmacy works collaboratively with the health care team across GCPH to deliver tailored and effective medication management that meets each patient individualised needs

- The HPC Contract is negotiated and controls applied at corporate level along with annual evaluation at local level and as required. The service meets regulatory state and federal laws
- Services provided include clinical pharmacy, imprest and dispensing with a small outlet on site
- Clinical Pharmacist participates on the Pharmacy, Infection Control Committees (including AMS) and the Medication Cluster
- Patients are seen on admission, during the stay and on discharge as noted in #225732 & #254681

- Clinical pharmacists collaborate with prescriber's and the patient to ensure an effective medication management plan, identify poly pharmacy issues, implement interventions as required, educate patients and discharge medications including contact with community pharmacies as required. Sample; # Patient RS Medication Profile Discharge given to patient and copy in patient record
- Consumer Fact Sheets sampled include "Antimicrobial Stewardship 2014" ACSQHC and "Amoxil Adult Preparation Consumer Medical Advice" MIMS 2017
- National Inpatient Medication Chart (NIMC) Audit June 2018 n=26 identified areas of improvement. QAP developed and an audit is planned for September 2018
- Telephone Drug Orders Audit Feb 2018 n=60 identified 2% compliance to policy and regulatory requirements. QAP developed including laminated signage to be placed in all patient records (sighted) requiring prescriber's signature. Re audit in June 2018 n=60 result> 64% compliance yielding a 62% improvement
- Online MIMS iPad erected on the wall for ease of access in medication rooms throughout the facility as seen in Ward 1
- Temperature Monitor of the drug fridge in Ward 1 was completed and signed to date. Facilities Management Department applies controls to ensure efficacy of refrigeration systems.
- All changes to policies, procedures and work instruction have controls applied by central management and in clinical areas change is communicated by the DCS by email and through the committee meeting structure to specific clinical areas

Planned activities/intended results have been achieved

CONTROL OF PRODUCTION AND SERVICE PROVISION - CLAUSE 8.5.1 - FOOD SERVICES:

The following process, documents and/or records were reviewed

The Food Services Program is underpinned by and compliant with the HACCP 7 principles of food safety. The team is lead/managed by an experienced qualified chef and the staff turnover is minimal (<4% hospital wide). The manager provided an end to end process account and walk through of the food service area. The team was awarded the Healthscope 2017 STAR Food Services Team National Best Team- Aspiration and the manager is currently leading the Healthscope Standardizing Food Service Project 2018 across Australia

- Food Act 2006 Audit Report 28/7/17 & 20/7/18 100% compliant
- Responsible Management of Licensed Venues-#J O
- Food Safety Supervisor 2012 #J O
- Eat Safe Gold Coast 5 Star-Gold Coast Council 2017
- GCPH Hand Hygiene Competition 2018 Hotel Services Superheroes. Keeping You Safe Contestant
- New staff participate in GCPH Induction and Food Services Induction that includes a buddy system-1 week supervision that may be extended if required
- E149 Orientation Manual June 2018 includes records and competencies for Food Safety Plan & Diet Codes # M L & # H W
- Food Services Training Learning Report 2018 includes annual competencies completed
- Food Handling and Hygiene Procedures (annual) # A R 7/7/18
- National Standards (NSQHS) GCPH 25/5/17 #L F
- Patient Centred Care Program # D B 7/6/17
- Daily Rounding facility wide includes food services and action required is logged on the Service Improvement Register and e-notification to the Food Services Manager who actions and formally

responds and visits the patients providing timely response that supports a well-developed customer service culture facility wide
- Qualtrics on line Patient Survey July 2018 n=87 within 1 week action completed re updating menus

Planned activities/intended results have been achieved

RESOURCES, COMPETENCE AND AWARENESS (INCLUDING PERFORMANCE APPRAISAL) - CLAUSE 7.2 - 7.4:

The following process, documents and/or records were reviewed

An effective recruitment & retention program is in place as indicated by the 4% turnover facility wide Investment in education and skills development has seen a growth in employment of educators and a new Diabetes Nurse who is highly experienced & qualified. All staff interviewed were knowledgeable of quality management and clinical standards that underpin the quality culture that is embedded in all job roles. Staff were aware of direct line management & reporting structures on an individual and work unit basis. Staff validated expectations of their job role and communication pathways.

- Organisational Chart July 2018
- Policy Updates are communicated electronically e.g. June 2018 Finance, HR & Administration
- 4.10 Mandatory Training Policy laminated and displayed in wards
- Mandatory Training is recorded on ELMO and completion reported at HODs Roundtable discussion monthly e.g. Ward 9 Mandatory Skills Assessment & Additional learning
- Education Needs Analysis 2018 Hospital wide
- Ward 6 Education Workshop VACC & PICC 29/1/2018 repeated quarterly.
- Cardiac Rehabilitation Cardiac Arrhythmias 2018>evaluation requested return of speaker
- Riskman incidents are analysed and education & training provided as required and detailed in the QAP
- Handover Education sessions June-July 2018 e. g. neurological observations
- Hospital Orientation reviewed 2018
- GCPH Hospital Orientation- Clinical Educators Work Process March 2018 plus evaluation forms>graphs
- Hospital Wide Performance Appraisal=95% complete (exclusive of staff on leave and new staff within 3 month period) e. g # 3060072 16/7/18 HR Coordinator, #3001496 Food Services Manager, #3058741 31/8/18 Diabetic Nurse Educator, #3039991 27/2/18 Head of Clinical Handover Cluster, # 3030399 4/5/18 A/NUM ICU (now appointed NUM)
- Orientation Pack 2018 Clinical & non Clinical
- Education sessions are available on video over a 24/7 period (rolling) for opportunistic viewing in the handover room in each work unit as identified in Ward 1

Planned activities/intended results have been achieved

PERFORMANCE EVALUATION - MONITORING, MEASUREMENT, ANALYSIS AND EVALUATION - CLAUSE 9.1- 9.3:

- The following process, documents and/or records were reviewed

Consumer satisfaction – consumer focus group meets quarterly with unique focus on aspects of patient journey has given a real focus on improvement. An example of changes initiated by Service Improvement Consumer focus group was signage indicating time limits for drop off zones at the front of hospital

- Areas improved within the hospital as a result of direct feedback received from the Consumer focus group include iPad provided to patients being admitted via the Consultation rooms to complete their admission; New process introduced for transferring patients between Dialysis and other areas of the hospital and Ward Orientation Manuals currently being updated to include information regarding Dialysis patients and their care.
- **Consumer quality action plan** details issue/problem/ opportunity for 2017/18. From the 34 issues identified 24 have been completed with 9 in progress.
- Consumer cluster focus on patient journey
- Quality action plan includes specific standard, clause, issue, strategy, responsibility, and time frame, progress and outcome/completion. All hospital departments have own Quality Action Plan
- **Monitoring compliance** with managers and team leader rounding and managers rounding with VMO's results from both rounding logs are emailed to performance improvement team – collated and uploaded on L drive and feed into the manager rounding spread sheet. The results of the team leader and manager rounding is key to the Net Promoter Score (NPS) of Patient Satisfaction. Results of team leader and manager rounding across the hospital have increased from 64 - 84% as the Net Promoter Score (NPS)
- Qualtrics is a live system used for **Patient Experience Survey** that automatically groups previous 30 days responses. The Survey is sent to patients admitted to the hospital if they wish to be part of the survey. Patients can opt in or out.
- The patient experience dashboard site indicates the overall rating for quality of treatments and shows % of patient selecting very good or above. Gold Coast Private Hospital (GCPH) NPS results from January to present show 81% (123 responses) The Net Promotor Score = Top Score equivalent of 10/10.
- GCPH currently sits at 85.7% for 1 July – 18 July (244) responses compared to the NPS score for July – September of 78%.
- The KPI target for NPS for all Healthscope facilities is greater the 50%GCPH compared with other similar Peer Group 1 hospitals = 73.5% for all hospitals and Peer group hospitals 78.9% **GCPH Jan – March 2018 score = 80.4%.**

Internal audit – (9.2)

- **Internal Audit monitoring schedule HSP no. 2.37 Policy and Procedure** details how to use the system how to analyse and one on one education.
- **Internal audit schedule** sighted identifying event, audit tool, frequency person responsible and completed for June – July 17/18; Internal audits are conducted by the Heads of Department or representatives of their own department.
- **Analysis of data and audit results** are tabled at committee meetings. Round Table meetings between the managers and executive team members ensuring accountability to action plans with address non-conformances and results not meeting expectations.
- **Service Improvement (Quality Meeting)** 28/6/18 Vaccination audit high risk = Maternity 100%; Pads= 100% and ICC = 90%.
- Audit by medical record team leader of ward clerks on compilation of clinical record – 90%

Planned activities/intended results have been achieved

IMPROVEMENT - NON-CONFORMITY AND CORRECTIVE ACTION, CONTINUAL IMPROVEMENT - CLAUSE 10 - 10.3:

The following process, documents and/or records were reviewed

Improvement Non- conformity and corrective action – all non- conformances an opportunity for improvement are reviewed on an ongoing basis through round table meetings between managers and executive.

- Rehabilitation medical documentation audit – annual audit of 50 records conducted by medical records compliance results less than 90%. Action plan developed for identified 11 areas of improvement. Action plan sighted and in progress – elements identified to review prior to next audit.
- **Continual Improvement** - Care tracks / Pathways annual audit by quality manager as part of the Governance audit – currently trialling medical care/ track - how to monitor documentation of variances. Recent innovative appointment by Nursing executive for a Clinical Documentation Specialist a Program to head clinical input into clinical documentation within the medical record. The Clinical documentation specialist to conduct training for discharge planner & diabetes education.
- Areas improved within the hospital because of direct feedback received from the Consumer focus group include iPad provided to patients being admitted via the Consultation rooms to complete their admission.
- New process introduced for transferring patients between Dialysis and other areas of the hospital and Ward Orientation Manuals currently being updated to include information regarding Dialysis patients and their care

• Planned activities/intended results have been achieved

Next visit objectives, scope and criteria

The objective of the assessment is to conduct a surveillance assessment and look for positive evidence to ensure the elements of the scope of certification and the requirements of the management standard are effectively addressed by the organisation's management system and that the system is demonstrating the ability to support the achievement of statutory, regulatory and contractual requirements and the organisations specified objectives, as applicable with regard to the scope of the management standard, and to confirm the on-going achievement and applicability of the forward strategic plan.

The scope of the assessment is the documented management system with relation to the requirements of ISO 9001:2015 Standard and the defined assessment plan provided in terms of locations and areas of the system and organisation to be assessed.

ISO 9001:2015
Gold Coast Private Hospital management system documentation

Please note that BSI reserves the right to apply a charge equivalent to the full daily rate for cancellation of the visit by the organisation within 30 days of an agreed visit date.

Next Visit Plan

Date	Auditor	Time	Area/Process	Clause
01/07/2019			Leadership/Management Responsibility - commitment, customer focus, policies, objectives and planning to achieve them, roles, responsibility, authority, management review	
01/07/2019			Context and Scope of Management System - external and internal issues, needs and expectations of interested parties, boundaries and applicability of the management system	
01/07/2019			Planning, Risks and Opportunities	
01/07/2019			Monitoring, Measurement, Analysis, Evaluation and Improvement – customer satisfaction, system performance, nonconformity, corrective action and continual improvement, analysis and evaluation	
01/07/2019			Review of previous BSI report findings	
01/07/2019			Internal audits and Inspections	
01/07/2019			Management System/Process Requirements/Documented Information	
01/07/2019			Operational planning & Control - review clinical areas - Perioperative suite; ECC; day service unit; maternity, ICU & CCU and ward areas	
01/07/2019			Resources - people, infrastructure, environment, organisational knowledge	
01/07/2019			Monitoring and measuring resources	
01/07/2019			Competence , Awareness & Training,	
01/07/2019			Externally provided processes, products and services - Procurement, Subcontractor Management	

Appendix: Your certification structure & ongoing assessment programme

Scope of Certification

FS 602771 (ISO 9001:2015)

For the provision of Acute Care, Emergency Department 24 hours, Intensive Care Unit, Cardiac and Thoracic Surgery, Coronary Care Unit, Cardiac Catheterization, Children's surgery, ENT, Gastroenterology, General Surgery, General Medicine, Medical Oncology, Gynaecology, Urology, Orthopaedics, Plastic and reconstructive Surgery, Rehabilitation, Renal Medicine, Children's medicine, Hospital in the Home, Respiratory Medicine, Maternity, special care and birthing suites. Hotel services and education and training, administration, operational infrastructure.

Assessed location(s)

The audit has been performed at Central Office.

Southport / FS 602771 (ISO 9001:2015)

Location reference	0047481180-000
Address	Gold Coast Private Hospital Pty Ltd 14 Hill Street Southport Queensland 4215 Australia
Visit type	Continuing assessment (surveillance)
Assessment reference	8756530
Assessment dates	19/07/2018
Audit Plan (Revision Date)	18/07/2018
Deviation from Audit Plan	No
Total number of Employees	1107
Effective number of Employees	557.8
Scope of activities at the site	For the provision of Acute Care, Emergency Department 24 hours, Intensive Care Unit, Cardiac and Thoracic Surgery, Coronary Care Unit, Cardiac Catheterization, Children's surgery, ENT, Gastroenterology, General Surgery, General Medicine, Medical Oncology, Gynaecology, Urology, Orthopaedics, Plastic and reconstructive Surgery, Rehabilitation, Renal Medicine, Children's medicine, Hospital in the Home, Respiratory Medicine, Maternity, special care and birthing suites. Hotel services and education and training, administration, operational infrastructure.
Assessment duration	3.5 day(s)

Shift Details

The shift patterns within the organisation rotate on a regular and frequent basis ensuring that a representative sample of shifts and appropriate staff are interviewed and seen over the certification cycle.

Morning and afternoon shifts were observed during the assessment with appropriate rostering of staff in critical areas such as Perioperative suite and CSD.

Certification assessment program

Certificate Number - FS 602771
Location reference - 0047481180-000

		Audit1	Audit2	Audit3	Audit4
Business area/Location	**Date (mm/yy):**	06/2017	07/2018	08/2019	08/2020
	Duration (days):	7.0	3.5	3.5	7.5
Leadership/Management Responsibility - commitment, customer focus, policies, objectives and planning to achieve them, roles, responsibility, authority, management review		X	X	X	X
Context and Scope of Management System - external and internal issues, needs and expectations of interested parties, boundaries and applicability of the management system		X	X	X	X
Planning, Risks and Opportunities		X	X	X	X
Monitoring, Measurement, Analysis, Evaluation and Improvement – customer satisfaction, system performance, nonconformity, corrective action and continual improvement, analysis and evaluation		X	X	X	X
Review of previous BSI report findings		X	X	X	X
Internal audits and Inspections		X	X	X	X
Management System/Process Requirements/Documented Information		X	X	X	X
Operational planning & Control - review clinical areas - Perioperative suite; ECC; day service unit; maternity, ICU & CCU and ward areas			X	X	X
Resources - people, infrastructure, environment, organisational knowledge		X	X	X	X
Monitoring and measuring resources		X	X	X	X
Competence , Awareness & Training,		X	X	X	X
Communication		X	X		X

Customer requirements for products and services - , tender and contract review, customer focus, communication and satisfaction	X	X		X
Design & Development	X			X
Externally provided processes, products and services - Procurement, Subcontractor Management	X	X	X	X
ISO 9001:2008 as per previous certification assessment plan	X			

Expected outcomes for accredited certification.

What accredited certification to ISO 9001 means

ISO 9001:2015 specifies requirements for a quality management system when an organization: needs to demonstrate its ability to consistently provide products and services that meet customer and applicable statutory and regulatory requirements; and aims to enhance customer satisfaction through the effective application of the system, including processes for improvement of the system and the assurance of conformity to customer and applicable statutory and regulatory requirements.

What accredited certification to ISO 9001 does not mean

1) It is important to recognize that ISO 9001 defines the requirements for an organization's quality management system, not for its products and services. Accredited certification to ISO 9001 should provide confidence in the organization's ability to "consistently provide product that meets customer and applicable statutory and regulatory requirements". It does not necessarily ensure that the organization will always achieve 100% product conformity, though this should of course be a permanent goal.
2) ISO 9001 accredited certification does not imply that the organization is providing a superior Product or service, or that the product or service itself is certified as meeting the requirements of an ISO (or any other) standard or specification.

Definitions of findings:

Non-conformity: Non-fulfilment of a requirement.

Major nonconformity: Nonconformity that affects the capability of the management system to achieve the intended results.
Nonconformities could be classified as major in the following circumstances:

- If there is a significant doubt that effective process control is in place, or that products or services will meet specified requirements;
- A number of minor nonconformities associated with the same requirement or issue could demonstrate a systemic failure and thus constitute a major nonconformity.

Minor nonconformity: Nonconformity that does not affect the capability of the management system to achieve the intended results.

Opportunity for improvement:
It is a statement of fact made by an assessor during an assessment, and substantiated by objective evidence, referring to a weakness or potential deficiency in a management system which if not improved may lead to nonconformity in the future. We may provide generic information about industrial best practices, but no specific solution shall be provided as a part of an opportunity for improvement.

O**bservation**:
It is ONLY applicable for those schemes which prohibit the certification body to issue an opportunity for improvement.
It is a statement of fact made by the assessor referring to a weakness or potential deficiency in a management system which, if not improved, may lead to a nonconformity in the future.

How to contact BSI

Should you wish to speak with BSI in relation to your registration, please contact your customer service officer.

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Fax: 1300 730 135 (International: +61 (2) 8877 7120)
E-mail (for corrective action plans): Please e-mail your corrective action plan to clientservices.au@bsigroup.com

Notes

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BSI, its staff and agents shall keep confidential all information relating to your organisation and shall not disclose any such information to any third party, except that in the public domain or required by law or relevant accreditation bodies. BSI staff, agents and accreditation bodies have signed individual confidentiality undertakings and will only receive confidential information on a 'need to know' basis.

This audit was conducted on-site through document reviews, interviews and observation of activities. The audit method used was based on sampling the organization's activities and it was aimed to evaluate the fulfilment of the audited requirements of the relevant management system standard or other normative document and confirm the conformity and effectiveness of the management system and its continued relevance and applicability for the scope of certification.

As this audit was based on a sample of the organization's activities, the findings reported do not imply to include all issues within the system.

Regulatory compliance

BSI requires to be informed of all relevant regulatory non-compliance or incidents that require notification to any regulatory authority. Acceptance of this report by the client signifies that all such issues have been disclosed as part of the assessment process and agreement that any such non-compliance or incidents occurring after this visit will be notified to BSI as soon as practical after the event.