Campbelltown Private Hospital

BUSINESS REVIEW REPORT

Date of Review	2nd and 3rd May 2017
Type of Review	Post certification
Site	42 Parkside Crescent, Campbelltown New South Wales 2560
Certification Standard	AS/NZS ISO 9001:2008
Scope of Certification	For the provision of anaesthetic, GIT endoscopy, medical, paediatric, rehabilitation and surgical services.
Scope of Review	As per Business Review Booking and Plan
Review Team	Dana Rowe (Lead Auditor) and Jane Hoffman (Team Member)
Report Signatory	Dana Rowe
Exclusions	7.3 Design and Development
Details and Registration of the Health Facility	NSW Health PH2159 dated 2nd February 2017 Anaesthesia, Cosmetic, Gastroenterology Endoscopy, Medical, Rehab, Paediatric and Surgical.
Certification Representative	Susan Hyland
Consumer Representative	Nil
Shifts	Morning and Afternoon

Summary

Campbelltown Private Hospital provides medical, surgical and rehabilitation services to the Macarthur and surrounding communities since 2007. There are currently 92 beds and eight operating theatres.This year they will be celebrating 10 years in operation.

Campbelltown Private Hospital is part of the Healthscope group and as such has corporate support.

There has been no change to scope since the last review. There were four open findings which were closed with two findings raised at this review

We believe that the health service organisation has the capability to systematically meet the requirements of the standard against the activities identified within the scope of certification. The auditor would like to thank the health service organisation for their openness, transparency and hospitality during the review.

Mandatory Reporting	
The management system includes an adequate process to identify the organisation's key processes and determine their controls;	Yes
The system provides an adequate description of the organisation and its on-site processes;	Yes
The system includes an overview of the applicable regulations (including licences/permits), and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place; and	Yes
The management system is effective in achieving the organisation's objectives.	Yes
Updates Since our Last Review	
If applicable, the effectiveness of taken corrective actions regarding previously identified nonconformities has been verified?	Yes
Any changes to the internal and external operating environment of the organisation?	No
Any changes to the documented management system?	No
Is there an awareness of and appropriate responses to changes in legislative requirements or recognised industry practices?	Yes
Has there been a balanced selection of standards audited such that all relevant standards are fully covered during the certification cycle?	Yes
Has there been any critical incidents/accidents (including transfers)? There has been 3 RCA performed since the last review (# 1603; #1609 and #1608) Documentation related to all RCA sighted with appropriate notification to Ministry of Health. All RCA have been report at the Medical Advisory Committee. There has been multiple transfers primarily to Campbelltown Public Hospital. Documentation related to all transfers sighted with appropriate management taken. All transfers are reported at the Medical Advisory Committee.	Yes
Inspection / audits by regulators? Ministry of Health 26th July 2016 Quality Review Summary Food Authority 02 December 2016 (License No 22586) A rating	Yes
Review Team Findings	
Open at the start of this review	04
Raised at this review	02
Closed	04
Remaining open at the end of the review	02

REQUIREMENT	EVIDENCE	COMPLIANCE
Quality Management System		
General Requirements	There is a documented policy in place, Quality Management and Core Procedure rev.4. 7th March 2017. This policy meets the requirements of the standard. The scope is documented and exclusion to 7.3 is articulated. There is a Quality Policy dated 17/03/2017 which is displayed on each clinical floor and is discussed at orientation.	Yes
Document Requirements	Document control requirements (inclusive of internal and external documents) is outlined in the Quality Management and Core Procedure policy rev.4 7th March 2017.This policy is supported by the corporate policy 1.14 Document Control March 2015. The policy includes approval process, document changes/modifications, management of obsolete documents. All documents sighted during the review contained evidence of document control.	Yes
Records Management	Not for review	
Management Responsibility		
Management Commitment including Customer Focus	Management commitment protocols have been documented within the Quality Management and Core Procedure rev.4 7th March 2017. The Quality Policy (03/2017) is displayed on each clinical floor and is discussed at orientation. The NSW Health license is displayed in the reception area for patients, staff and visitors to view. Patients have access to health related literature including the Australian Charter of Healthcare Rights and complaints management process. There is a corporate policy in place 2.16 Rights and Responsibilities-Patient July 2016. Customer focus was evident with patient feedback and partnering with consumer activities.	Yes
Policy, Objectives and Planning: Continual Improvements	Quality Policy dated 17/03/2017 is displayed on each clinical floor and is discussed at orientation. Objectives are divided into 10 key areas • Governance- Clinical, Risk Management and Credentialing • Consumer • Infection control • Medication Safety • Patient Identification • Handover • Blood • Pressure Injuries • R&R Clinical deterioration • Fall prevention Objectives are an input into Management Review Committee. Departmental Managers are required to complete a "scorecard" which contains the following data financial, occupancy, HR, Risk Management, complaints, surveys meetings e. An action plan is then completed when results	Yes

REQUIREMENT	EVIDENCE	COMPLIANCE
	are not optimum. The "scorecards" are reported at Management Review Committee. There is a strategic plan 2017 in place which is formulated annually by the General Manager.	
Responsibility, Authority and Communication	There is both corporate (3/2017) and local facility organisational charts (20/04/2017 v.5.6) with departmental charts also available. The organisational charts outline the relationship of personnel within the hospital and also the corporate arena. There are documented position descriptions in place- Quality and Risk Manager 9/2016 v.2; Registered Nurse 4/2013; Sterilising services 7/2013. The Quality and Risk Manager is the appointed Management Representative for the Quality Management System. Internal communication is facilitated through the committee structure, all committees have a standing agenda and terms of reference. Communication is further strengthened through staff newsletters, HICMR newsletters, executive newsletters and education sessions.	Yes
Funding Framework	Not for review	
Management Review	Management review is outlined in the Quality Management and Core Procedure rev.4. 7th March 2017. Management review Committee is conducted monthly with comprehensive minutes maintained. Inputs include but not limited to finance; supply process; legalisation updates; education; training status; infection control; quality and safety; WH&S; Incidents; monthly inspection; Riskman data analysis; cluster meetings; departmental reports (inclusive of scorecard); clinical review; audits and policy and procedure. Minutes sighted Dec 13th, 2016 and 9th Feb 2017.	Yes
Medical Advisory Council and VMO Files	Not for review Observation #6 It is unclear how the facility manages WWCC for the VMO.	Observation #6
Use of Certificate, Mark(s) and Advertising Material	Campbelltown Private Hospital has the Global Mark certificate displayed by the lifts on each floor. The certificate mark is not used on any of the marketing documentation or brochures. The internal documentation does not include the certification mark.	Yes
Resource Management		
Provision of Resources	Not for review	
Human Resources	Human resource requirements is outlined in the Quality Management and Core Procedure rev.4. 7th March 2017. There is a comprehensive orientation program in place which may be conducted monthly if required depending on hospital requirements. (Orientation records for 21st March 2017, 20th February 2017 and 25th November 2016 sighted). The	Yes

REQUIREMENT	EVIDENCE	COMPLIANCE
	orientation program is supported by the orientation checklist and a comprehensive orientation Staff Handbook 2017. Education is completed on line via ELMO and departmental in-services. Appraisals are completed 3 months after commencement of employment and then annually.	
Infrastructure and Work Environment	Not for review	
Service Realisation		
Patient Episode and Consumer Interview	The following patients were included in the witness audit of episode of care: MR244417, MR244398, MR242961, MR223710, MR52971, MR244061, MR529571 A preadmission set of documents is completed by the patient. These are reviewed by the hospital before admission and any potential risks are brought to the attention of the nursing staff and follow up with the patient may be required. Patients are admitted in a private room by a Nurse. The admission includes but is not limited to a review of the pre-admission information, medical and medication history, allergy and infection status, NBM times, patient ID, consent check. Discharge arrangements for day surgical patients are verified. An Alert sheet HRM000, Infection status HRM4.22, Patient verification of details CR106, Falls risk HRM7.9, Pressure Risk HRM7.5, consent HRM47A are all completed. The NSW medication chart and observation charts are in use. The admitting nurse provided the patient with full explanations at all time of what was happening and why. She listened to the patient's responses and answered all questions raised. The peri-operative and recovery episodes were witnessed. They included good handover at all points of transition of responsibility from one member of staff to another. The patient risks were included in the handover. Pre-op check CR251 is completed. Time out was clear and all members of staff stopped to listen (Surgical safety check (HRM9.1) The recovery care was inclusive of the patient as soon as they were awake enough to participate. Pain control was offered and administered effectively in line with the medication administration requirements. On return to the ward the patient was made comfortable. Wound was checked, pain status clarified, observations taken and the patient was made comfortable. This was all documented on the patient notes. Equipment was cleaned between each patient use is all clinical areas. Hand hygiene was generally completed as required especially by the nursing and physiotherapy team.	Improvement Request #9

REQUIREMENT	EVIDENCE	COMPLIANCE
	The patients' privacy and dignity was maintained at all times. The rehabilitation episode of care includes group gym sessions and/or individual session with the physiotherapist. An occupational therapist is available as required. Goals are set for the patient and the appropriate care documented Physiotherapy initial assessment CR395, Occupational initial assessment CR411, Exercise sheets (e.g. TKR 412), Progress notes are completed in chronological order with the date, time, signature, name and designation recorded. Patient MR111299 (surgical patient) and MR205220 (rehabilitation patient) were interviewed following verbal consent. Both were happy with the care they had received so far. Both felt the communication from all members of staff was good, hand hygiene had been observed frequently and their ID bands were checked whenever the nurses gave medication. If they had concerns the nursing staff listened and acted appropriately to rectify the problem. Finding # 9 improvement request has been raised as best practice was not adhered to regarding patient safety - Surgical assistant was observed to bring a drink into the operating theatre whilst a patient was present. Missed moments of hand hygiene by the surgical assistant and the anaesthetist was observed. Medication labelling was not adhered to as the anaesthetist was observed to produce a syringe from his breast pocket and administer the unidentified substance and place the syringe back into his breast pocket.	
Sterilisation, Infection Control and Staff Health	CSSD flow of equipment processing is clear and dirty areas are physically separated from clean. There is a separate scope processing unit with 3 scope reprocessing machines. The sterile stock area is clean and very tidy. The stock is stored off the ground as required in AS4187 and humidity and temperature of the room is recorded. The recordings are all within acceptable range. A gap analysis and implementation plan for AS4187:2014 has been completed in consultation with HICMR. A significant amount of the actions required have been closed out including an RO washer and certification of 2 of the 3 washer -dryers to the new standard. Records of instrument and scope reprocessing was witnessed and records sighted as well as the start-up checks on the equipment. The following infection control related audits have been completed so far this year: Hand hygiene, ANTT, vaccine storage, NAPS and SNAPS, PPE, transmission based precautions, antimicrobial stewardship, invasive devices. Areas for improvement have been identified in the audits (hand hygiene and antimicrobial stewardship) and discussed at the relevant meetings. Additional training has been provided and the Infectious Diseases consultant and pharmacist will now be present at the infection control meetings either in person or through conference call.	Yes

REQUIREMENT	EVIDENCE	COMPLIANCE
	The Infection control coordinator has expanded the data base for staff health in relation to vaccine preventable diseases and allergies so that all existing staff are included. It is evident that a lot of work has gone into getting existing staff details regarding vaccination status. Those staff who have not yet provided the information have been sent letters and followed up in person. Approximately 80% of the current staff have provided the required information. Therefore finding #2 is now closed.	
Purchasing: Control of Suppliers and Contractors	Not for review	
Equipment Maintenance and Calibration	There is a Healthscope procedure in place which identifies the requirements for equipment service and calibration. Maintenance has a comprehensive database which includes all items requiring service/calibration. The following information is included - company, frequency, contractor insurance, company registration, relevant certificates/qualifications. All documentation reviewed was current. Theatre holds the service records for the CSSD and theatre equipment. The general medical devices are serviced and calibrated by an external contractor. The last service and calibration check was completed in July and Aug 2016. The theatre equipment is serviced and calibrated separately. The validation and service records were sighted. All had been completed in the last 3 months or installed and certified since December 2016. Testing and tagging was evident on all equipment. The tags state the frequency of the testing.	Yes
Support Services: Catering, Cleaning, Linen and Waste Management	Not for review	
Measurement, Analysis and Improvement		
Patient Satisfaction and Complaints Mechanism	Patient satisfaction protocols are outlined within the quality management system: 1.33 Patient Satisfaction Survey (Sept 2016); 1.05 Partnering with Consumer (Jan 2016); 1.08 Complaints Management (March 2015). Satisfaction survey results Jan-March 2017 sighted all results were positive. A Patient centered care survey is completed annually this year it was completed electronically as a piolet with a good return rate. Patient feedback is an input into Medical Advisory Committee and the Management Review Committee. There is a documented Complaints Management Policy 1.08 in place dated March 2015. All complaints are managed by the Director of Clinical Services. There is a complaints register maintained and complaints sighted were found to be appropriately managed. Complained are entered into Riskman and managed through this process. Complaints sighted ID #34676; ID #34683 and ID #29309.	Yes

REQUIREMENT	EVIDENCE	COMPLIANCE
Internal Audit	Internal auditing protocols is outlined in the Quality Management and Core Procedure rev.4. 7th March 2017.There is also a documented corporate procedure in place 2.37 Auditing Internal Quality Feb 2016.This policy is supported by the CPH Internal Audit Schedule 2017. The schedule is inclusive of all areas of the Quality Management System and NSQHSS. Therefore finding #4 is now closed. Reporting of internal audits in an input into Management Review Committee Via the KPI report which is completed quarterly. Reporting was inclusive of all areas of the internal audit. Therefore finding #3 is now closed.	Yes
Performance Indicators	There is a documented procedure 2.33 Clinical Indicators Minimum Data Set in place. The monthly KPI are inclusive clinical indicators which are collected and benchmarked both internally and externally. ACHS 1st half 2016 report sighted, currently the facility collects 7 sets of data. Indicators are reported at MAC and MRC. Rehabilitation statistics are submitted to AROC. All data is validated by an independent statistician engaged by corporate office prior to publication.	Yes
Control of Nonconformities	Control of nonconformities is documented within the Quality Management and Core Procedure rev.4. 7th March 2017.There is corporate policies to support this procedure 1.34 Risk management and integrated risk register April 2014; 1.35 Sentinel event management August 2014; 2.13 Incident notification and management February 2015; 2.29 Risk management –Clinical February 2015 and 1.38 Risk Management system –use of riskman February 2015. Riskman is utilised for all incident reporting with both corrective and preventative actions documented. All incidents sighted were actioned appropriately. (ID #1053033; ID #1059269 and ID #29309) Finding # 5 is now closed as the status of RiskMan ID# 1011121 has been reviewed within MAC dated 17th May 2016.	Yes
System Improvements: Corrective and Preventive Action	Both corrective and preventative actions are documented within riskman.	Yes

Particulars

Review Team Declaration

We confirm that for the purpose of this review, the review team:

- Were independent from the company listed above and did not have any conflict of interest;
- Had sufficient resources and competences to complete its review and reach its conclusions; and
- Had the appropriate credentials to perform this review in accordance with Global-Mark and applicable accreditation requirements.

Comment and Disclaimer on this Report

- This report does not and should not be seen as advice. Please consult a qualified advisor or consultant for advice.
- Due to the sampling nature of third party business reviews, the time available and samples size, some issues, non-compliances or improvements might not have been identified in the present report. This does not imply that these issues do not exist, or are in compliance. Employees, management and other stakeholders of the organisation need to and are responsible for, continuously identifying and taking necessary controls to ensure continued compliance with the standard(s) and continual improvement.
- Readers of this report should make judgement taking the above into account.
- The report is confidential, and is owned by the organisation listed above, Global-Mark Pty Ltd and the review team members who participated in its preparation.
- Global-Mark reserves the right to make this report available to regulators, and/or funding providers if requested.

When reading or using this report the compliance column should be completed as:

- Yes complies
- No, does not comply, non-conformance raised
- Improve: could improve, improvement request raised
- Observation: observation raised

Attendance to Opening and Closing Meeting	Opening	Closing
Chris Profitt (General Manager)	✓	✓
Amanda Ginger (Acting National Accreditation Manager Healthscope)	✓	x
Susie Cicuto (Director of Clinical Services)	✓	✓
Susan Hyland (Quality and Risk Manager)	✓	✓
Louise Jones (Finance Manager)	✓	✓
Vicki Fursey (Relieving DSU NUM)	✓	x
Rebekah Short (Executive Assistant)	✓	x
George Kalogiannis (Maintenance Manager)	✓	✓
Karen Wilcock (Environmental Services Manager/Infection Control)	✓	✓
Del Nicholson (WHS Manager)	✓	✓
Pam McIlwain (Perioperative Services Manager)	✓	✓
Deborah Chant (Rehab NUM)	✓	✓
Alex Ruisi (Supply Manager)	✓	x
Terry Dickson (Catering Manager)	✓	✓
Eva Naidoo (PACU NUM)	✓	✓
Annmaree Kervin (Sterilising Services Manager)	✓	✓
Tania Patterson (Level 2 Surgical NUM)	✓	x
Sharita Ram (Level 3 Surgical NUM)	✓	✓
Shahista Khan (Allied Health Manager)	✓	✓
Dawn Holden (Billing Manager)	✓	x
Anna Broun(Theatre 4 NUM)	✓	✓

Dana Rowe(Global-Mark Lead Auditor)	✓	✓
Jane Hoffman(Global-Mark Auditor)	✓	✓