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

The Hills Private Hospital

Baulkham Hills, NSW

Organisation Code: 12 59 84

Survey Date: 19-21 September 2017

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:
The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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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.

Organisation: Hills Private Hospital, The
Orgcode: 125984

Survey Report

Survey Overview

Management and staff of The Hills Private Hospital (THPH) presented well for the National Safety and Quality Health Service (NSQHS) Standards survey undertaken over three days from 19th to 21st September 2017, demonstrating evidence of their achievements in improving care and services for patients. The hospital is well appointed, clean and aesthetically pleasing.

The Hills Private Hospital provides well established Mental Health and Rehabilitation services. The hospital has developed particularly impressive local features in the management and promotion of both its policies and quality activities and projects. This infrastructure is ably supported by a range of human resource functions and processes.

The survey team noted that the hospital's casemix, particularly within the mental health service, had changed in response to community demand and had responded by progressively upskilling their clinical workforce. The organisation is congratulated on the extensive education program and the provision of staff access to external online training that has ensured that they have a high level of awareness of safety and quality principles and issues.

The organisation has made great strides since the last survey in promoting genuine consumer participation. Three consumer representatives consult with patients to identify issues to bring to management's attention. Perhaps the most potent and unique mechanism established to engage consumers in hospital affairs are the Monthly Patient Forums that have been operational for four years and have yielded a plethora of design and redesign outcomes that have improved the physical environment of the hospital as well as significant aspects of program delivery.

The recent introduction in the Rehabilitation wards of an interdisciplinary WebPAS-based clinical handover is applauded, as is the Mental Health Service for finding innovative ways to encourage patient participation in bedside clinical handover. This is a traditionally challenging issue for Mental Health and Drug and Alcohol programs.

The Hills Private Hospital clearly benefits from the Healthscope Corporate support through the policy and clinical governance framework, shared learnings and involvement in all of the Healthscope Cluster Working Groups which continue to focus on requirements of each of the National Standards. Significant work has been undertaken in the last year under the leadership of a revised executive team to equip managers and staff with the knowledge and expertise to meet increasing activity and service delivery.

The surveyors were impressed with the high degree of team work and the integration of new services for patients. Multidisciplinary team work in both fall and pressure injury prevention has resulted in injury rates well below peer average is most impressive. Management and staff continue to demonstrate commitment to the process of increasing involvement of consumers.

Overall, The Hills Private Hospital has performed well and staff are congratulated on their enthusiasm and achievements demonstrated during this National Standards survey.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The organisation has in place an impressive framework for the development and dissemination of policies. The impact on patient safety and service quality is routinely considered in major business decision making by the Executive and this is reflected by the utilisation of a number of mechanisms. These include CAPEX (Capital Expenditure template for business proposals) and the imperative of alignment with the THPH's Strategic and Business Plans, Risk Profile and Quality and Safety Plan.

The organisation's peak governing committee (Executive Committee) routinely reviews and responds to a cohort of benchmarked ACHS (N=34) and Healthscope (N=59) KPIs, together with other safety and quality data, on a monthly basis. All staff are aware of their delegated safety and quality roles and responsibilities through their respective Position Descriptions and supported to perform them through their mandatory participation in the annual Performance Development and Review process. Additional support is provided by their participation in interdisciplinary team meetings and having access to supervision and/or support from departmental heads or managers.

Healthscope has a contract with an agency that stipulates the training and skill requirements for agency nursing and allied health staff prior to their working at any of their hospitals including THPH. The hospital has minimal reliance on agency staff as it has a casual nursing pool. The generic orientation program was last reviewed and updated in September 2017 and the mandatory online competency-based training package is monitored on a monthly basis resulting in near 100% compliance facilitated by off-site access through the Electronic Learning Port (ELMO).

The organisation's risk register is accessible through the versatile online RiskMan electronic system. It is an impressive document that is user-friendly in terms of format and utilisation. It is reviewed by management on a monthly basis to assess the potency of the controls and / or mitigation strategies put in place. There are currently 107 items on the register with patient falls and manual handling being the top clinic risks. The system is closely aligned with the corporate risk register and prompts for inclusion in the register are provided by the contents of the monthly Healthscope Shared Learnings reports that are relevant to THPH.

THPH's quality improvement framework is exceptional and risk mitigation strategies are usually reframed as quality improvement activities or projects. The surveyors verified evidence of significant improvements across all hospital departments as a result of the activation of quality improvement projects. These included the enhancement of the sterile medical storage rooms in the wards, the purchase of high density mattresses in the Rehabilitation wards and the introduction of the electronic leave register in the Windsor Road Unit. Oversight of the risk and quality portfolios is provided by the Quality Manager who reports on the status of both to the Executive through the Quality and Clinical Governance Committees.

Clinical practice

Clinical practice involving the use of contemporary evidence-based clinical guidelines and appropriate risk assessment and escalation of care protocols is monitored by the inter-disciplinary clinical review meetings held at least weekly in each ward and verified annually by the results of the clinical documentation audit. Clinical guidelines are developed or sourced at the corporate level, are subject to document control and accessible through the Healthscope intranet (HINT).

All patients are risk assessed against a cohort of potential risks pre-admission and an alert is documented on the front cover of the medical file if a risk is identified. A Medical Emergency Team (MET) is onsite 24/7 to promptly respond to patient deterioration in health status and all MET calls are reviewed by the Quality Manager to elicit ideas for improvement.

The hard copy medical record is always located in the patient's ward with the clinical file at the bedside and main record in a locked cupboard in the Nurses' Station. A hospital-wide documentation audit is conducted every August with the last audit indicating 95% compliance with policy requirements.

Performance and skills management

The scope of practice for all VMOs is negotiated at recruitment and a database on each doctor's APHRA registration, insurance and medical indemnity details is maintained by the Chief Executive's PA and formally reviewed by the Executive on an annual basis. The hospital's casemix recently changed with the Windsor Road Unit admitting patients with drug and alcohol (D&A) issues. This was planned in the strategic planning process so that prior to it occurring the hospital recruited a medical specialist in D&A problems and a psychologist with expertise in DBT.

The scope of practice for nurses and Allied health staff is documented in their respective Position Descriptions and a database for both these categories of staff is maintained and monitored by the corporate HR Department and locally by the staff member's departmental head. The annual mandatory Performance Development and Review process includes a review of the nurse and allied health staff member 's scope of practice that is also included in their position descriptions. Clinical supervision is available to all Allied health staff on a one-to-one basis. Nursing staff utilise the clinical review meeting as required as the venue for their informal clinical supervision and mentoring.

The full-time Staff Development Coordinator (SDC) has developed an annual Education Calendar that provides training opportunities for staff over and above that provided in the mandatory training program. A database of each staff member's participation in educational courses is maintained by the SDC. Advanced training in certain subjects is provided by the SDC to upskill staff to provide an evidence-based intervention for emerging new patient diagnostic groups and/or issues, for example wound management and dementia).

Staff provide feedback to the Executive through their participation in a range of activities including the annual Healthscope Your Voice Counts surveys, the annual Staff Development and Review process, the Staff Engagement Survey and RiskMan reporting. All surveys are treated as quality improvement projects with management implementing associated Action Plans to address issues identified.

Incident and complaints management

The organisation has in place multi-faceted contemporary incident and complaints management frameworks that utilise RiskMan for their incident/complaints registration and subsequent management.

The Quality Manager oversees these systems and provides regular trended reports to the Executive and from there to Healthscope corporate committees for their respective review as well as providing targeted reports for each unit to review and respond to as required. Falls, manual handling and medication errors are the most frequently reported incidents and the survey team sighted Action Plans that were being implemented to minimise their re-occurrence. The auditing and support by the onsite Clinical Pharmacist was proving pivotal in addressing medication issues. With respect to complaints, about 20 are formally registered each year and THPH followed Healthscope policy in managing them.

An emerging issue that is reflected in both incidents and complaints is the management of the deteriorating patient. A quality improvement project has been initiated that involves the rotation of staff in the acute units at nearby Norwest Hospital, enhanced staff training, the introduction of purposeful rounding and the identification of ward champions. All staff have completed online training in open disclosure and the Director Medical Services is actively promoting it as the basis for all communications with patients and their carers.

Patient rights and engagement

Patient rights and responsibilities are actively promoted by their inclusion in the Patient Compendium that is explained to the patient on admission and via posters prominently displayed throughout the hospital. The most recent patient satisfaction survey indicated that 96.7% of patients understood their rights and responsibilities. Communication issues (language, cognitive impairment, hearing loss, etc) are identified at the pre-admission stage and if present (this is rare) notification is included on the Alert Page at the front of each patient's medical file. In certain instances, provision is made for a carer to stay in hospital with the patient during their stay.

It is corporate policy for patients and carers to be partners in care planning and auditing indicates that the hospital achieves a high level of compliance with this requirement.

Patients are required to sign two consent forms prior to admission, one for informed financial consent and the other for consent to medical treatment. The only other consent form used is for patients receiving a blood transfusion. Auditing of consent is included in the annual documentation audit with THPH achieving near 100% compliance. The consistent patient profile indicates a 96% level of patients speaking English. Interpreter services are accessible to that small proportion of patients who require this service. Patients with or requiring an Advance Care Plan are identified at pre-admission and this information is included in the Alert Page at the front of the medical file.

Medical files are paper-based and stored securely in the Nurses' Station of the patient's ward with the working Clinical File that includes prescribed medication at the bedside. There are a range of corporate policies with respect to formatting, information security, confidentiality and privacy, storage and retention and a host of other issues as they pertain to the medical file. The annual documentation audit covers most of these issues and 100% or near 100% compliance is consistently achieved. There is a part time Health Information Manager onsite and Healthscope has National and State Health Information Managers who monitor and support each site including THPH.

The hospital collects patient feedback from a variety of sources including the quarterly Patient Satisfaction Survey, monthly Patient Forums, the Official Visitors (for mental health patients) and the Patient Representatives. This data is first presented to the Standard 2 committee for review and thence to the Executive via the Quality Committee. The survey team was provided with a series of improvements that have resulted from this feedback including changes to the meals provided, changes to the air conditioning system and improvements to patient information documents.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	MM
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	MM
1.6.2	SM	SM

Action 1.1.1 Core

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

Surveyor Comment:

The organisation has a comprehensive framework in place for the development and dissemination of policies that is informed by Healthscope corporate guidelines. THPH's framework is managed by the Quality Manager who has adopted the LEX system to set expiry and review dates for all policies. Local policies are developed in consultation with key subject matter experts and stakeholders to address local issues that are not addressed by corporate policies. Each policy is risk rated on a 3 point scale to determine the frequency of review and risk status is determined by the current profile of THPH's risk register and the quarterly Healthscope Shared Learning reports.

Selection of relevant policies for each hospital department/unit from the 412 ratified corporate policies and 80 local policies is determined by the Quality Manager in consultation with the respective departmental manager. All high-risk policies are reviewed annually, are competency based and accessible online on the intranet. Each manager is responsible for ensuring that their respective staff are cognizant of the cohort of policies impacting on their department. Oversight of this process is provided by the Quality Manager.

Review of incidents registered in RiskMan indicates minimal association with breeches of policy compliance and a recent audit of a sample of THPH's policies elicited a 100% compliance rate with corporate policy template requirements. The organisation achieves an MM rating on this Action due to the continuous capacity of the efficient local policy framework to provide THPH Executive with sustained and measurable assurance of optimal compliance with all policies.

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

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

Surveyor Comment:

Quality improvement is embedded in the culture of THPH. There is a multi-faceted framework that promotes this culture in a sustainable way. The components of the framework include the permanent Quality Manager position, the hospital's annual Safety and Quality Plan the implementation and evaluation of which is overseen by the peak Quality and Safety Committee.

The inclusion of Quality Improvement in both the orientation and mandatory training programs, as a standing agenda item of all committee meetings and as a core responsibility in the generic Position Description template, the quarterly Quality & Safety Bulletin and the impressive Quality Activities and Projects Register and Annual Audit Program is evident over many years.

The latter demonstrates a close link between risk management and quality improvement and a good understanding organisation-wide of the principles underlying continuous quality improvement. The surveyor team considers that THPH achieves an MM rating on this Action because of the proliferation of genuine quality improvement projects and activities across all hospital departments.

Surveyor's Recommendation:

No recommendation

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	MM

Action 1.13.2 Core

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

Surveyor Comment:

Staff of THPH are provided with a plethora of educational opportunities to enhance their understanding and use of safety and quality systems.

These include mandatory training on Quality and the utilisation of RiskMan, ward/department participation in each of the ten NSQHS Standard Working Parties, regular reports on a department's incident and hazard profile as well as relevant audit results and associated Action Plans, Healthscope Shared Learning Bulletins, the hospital's Quarterly Quality Bulletin, feedback from Healthscope National Standards Cluster Groups, the well-attended hospital Quality Workshop in late 2016, regular in-services on quality and safety and advanced education sessions including those by provided by Norwest Hospital CNEs on the deteriorating patient.

The outcome of this enhanced education and support is the development and implementation and ongoing evaluation of multiple quality improvement projects by each department to address deficit issues to ensure compliance with the requirements of each of the ten NSQHS Standards and demonstrable continuous improvement in patient quality and safety. The surveyor team consider that this outcome is exceptional and accordingly an MM rating is achieved on this Action.

Surveyor's Recommendation:

No recommendation

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

Organisation: Hills Private Hospital, The
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STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

THPH's approach to addressing the compliance requirements of Standard 2 is informed by corporate policies including the Partnering with Consumers Policy January 2016 upon which is based the THPH Partnering with Consumer Engagement Plan 2017-2018. Implementation of this plan is well underway and is monitored by the Standard 2 Partnering with Consumers Committee.

Membership of the committee currently includes three Consumer Representatives (two representing the Rehabilitation service and one representing the Mental Health service) and there are plans to recruit a further two representatives. The committee reports to the Quality Committee that in turn reports to the peak Executive Committee. The corporate policy defines six channels for consumer involvement including consumer representatives on committees, patient forums, quality improvement projects and patient satisfaction surveys.

THPH is particularly congratulated on the staging of monthly Patient Forums for the past four years and the development of a rehab patient journey video that will be used for staff education and hospital promotional purposes. Many of the hospital's initiatives in consumer participation are very recent and will need to be bedded down and evaluated to determine their sustained effectiveness. The survey team suggests that the role of the consumer representative be reviewed to determine if there are any constraints associated with the position's voluntary status, limited regular hours and indirect access to the Executive. On average 98% of patients admitted to THPH speak English and the majority are from white Anglo-Saxon backgrounds. Arrangements are in place, nevertheless, to provide support to those with significant communication issues.

The organisation was able to demonstrate consumer participation in strategic/operational planning and decision making about safety and quality through the Minutes of the Standard two committee (where safety and quality KPIs are tabled and discussed) and consumer membership of facility planning workshops.

Consumer representatives on entering the organisation participate in a three-hour orientation program that is based on the hospital's general orientation program and includes infection control, work health safety, emergency management including evacuations and signage.

Healthscope has demonstrated strong commitment for consumers to review and modify as required their policies and publications regarding patient information. At time of survey THPH had arranged for their consumer representatives to review and ultimately endorse 14 local documents providing patient information in the previous 12 months. This is now standard practice.

Consumer partnership in designing care

Consumers attending the monthly Patient Forums provide feedback to the Executive that involves the design and re-design of health services both with respect to infrastructure and program content.

Examples include the planned establishment of a smoke free outside area for patients, improved lighting and signage in the front reception area, the purchase of special fridges for ice packs and the introduction of hot breakfasts twice a week.

It is a mandatory requirement for all clinicians to complete an online competency-based Healthscope training course in Patient-Centred Care and a high level of compliance was achieved with respect to this requirement.

The aforementioned patient journey video is now included in the hospital's orientation program and it is strongly suggested that the regular inclusion of patient representatives in the organisation's annual mandatory training program be considered to enhance compliance with the requirements of Action 2.6.2.

Consumer partnership in service measurement and evaluation

Hospital information relevant to current and potential patients is accessible on the THPH website and the MyHealthscope website. The graphical presentation of safety and quality KPI data has been the subject of review and refinement by consumer representatives. In the hospital wards, this same information is prominently displayed on their respective Quality Boards that can be easily viewed by patients and visitors.

Consumer Representatives, through their membership of the Standard 2 committee, participate in the analysis of trended and benchmarked safety and quality KPI data reflective of the hospital's performance. These representatives also participate in a number of relevant quality improvement (QI) projects including the review of the Patient Compendium and the development of a Total Knee and Total Hip Replacement Precautions brochure for affected patients. It is suggested that this level of participation could be further developed by Consumer Representatives taking the lead role in the development and implementation of one relevant QI project each year. This could be associated with a contemporary issue elicited from the Patient Forums or other patient feedback mechanisms.

Patient Satisfaction Surveys and other patient feedback are reviewed at meetings of the Standard 2 committee.

In addition, this committee reviews all complaints and compliments received in the preceding month. This review process has resulted in, for example, improved patient access to newspapers and favoured food.

A major QI project associated with patient feedback currently involving the Patient Representatives is the review of the Patient Communication Boards placed in every patient's room. They are under-utilised and the project aims to address this issue. It is suggested that the Terms of Reference of the Standard 2 committee be reviewed to ensure the sustainability of Consumer involvement in similar QI projects.

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	MM
2.6.1	SM	SM
2.6.2	SM	SM

Action 2.5.1 Developmental

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

Surveyor Comment:

Over and above the initiatives contained in THPH Partners with Consumers Engagement Plan 2017-2018 the organisation has been conducting Patient Forums 10 times/year on a rotational ward basis since 2014. Patients from every ward are personally invited to attend with the average attendance ranging from 8 to 10 each year. Initially only the Quality Manager and Front Office Manager facilitated the forums using a structured question approach.

This was enhanced in late 2016 with all members of the Standard two committee including a Consumer Representative being invited and the patients being additionally consulted about ways to improve the Patient Compendium and subsequently the utilisation of the Patient Communication Boards located in Patient Bedrooms.

This unique consultation mechanism has directly achieved a range of significant outcomes that are associated with an improved journey for patients during their hospital stay. Hot breakfasts are now provided twice a week, new free standing patient ice pack fridges have been purchased in response to the complaint about the coldness of the ice packs, there has been improved response time by staff to patient call bells and the air conditioning system in the older part of the hospital building has been revamped to provide an appropriate room temperature.

Three projects emanating from the forums and awaiting funding, are the development of an outdoor seating area; improving the quality of patient Wifi; and purchasing Foxtel for patient viewing.

These Patient Forums have been the subject of formal evaluation and the average satisfaction rating by patients each year has grown from 80% in 2014 to 92% in 2016.The Hospital Executive values this mechanism as a true barometer of general patient satisfaction with the hospital and has demonstrated willingness to respond quickly to pressing issues promoted by patients during the forums. The sustainability of these forums over a protracted period to contribute significantly to the design and redesign of the hospital fabric and programs is impressive and an MM rating is achieved on this Action.

Surveyor's Recommendation:

No recommendation

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Governance and management systems for healthcare associated infections (HAI) are well supported by relevant Healthscope, HICMR and local policies. Access to all policies and HICMR newsletters are available to staff on the intranet. Results of annual risk assessments for 2015- 2017 consistently demonstrate greater than 90% compliance with policy. Equally impressive is the rigour applied to ensuring all related action plans to correct less than adequate performance, are completed in a very timely manner.

An Infection Control Coordinator (ICC) is responsible for supporting and implementing systems and processes of the infection control system. The current infection prevention and control plan is endorsed and regularly reviewed by the Infection Control Committee and THPH Executive.

The surveillance system of HAIs is well established to provide data as required for ACHS indicators and Healthscope KPIs. This system has recently been streamlined through a quality improvement process undertaken by the ICC in consultation with key pathology staff to ensure more timely surveillance data is available.

The effectiveness of the Infection Prevention and Control (IP&C) system is regularly reviewed by the THPH Infection Control Committee and THPH Executive.

Infection prevention and control strategies

Governance and management systems for healthcare associated infections (HAI) are well supported by relevant Healthscope, HICMR and local policies. Access to all policies and HICMR newsletters are available to staff on the intranet. Results of annual risk assessments for 2015- 2017 consistently demonstrate greater than 90% compliance with policy. Equally impressive is the rigour applied to ensuring all related action plans to correct less than adequate performance, are completed in a very timely manner. Consequently, THPH presents as a facility that is environmentally clean, aesthetically pleasing and uncluttered.

An Infection Control Coordinator (ICC) is responsible for supporting and implementing systems and processes of the infection control system. The current infection prevention and control plan is endorsed and regularly reviewed by the Infection Control Committee and THPH Executive.

The surveillance system of HAIs is well established to provide data as required for ACHS indicators and Healthscope KPIs. This system has recently been streamlined through a quality improvement process undertaken by the ICC in consultation with key pathology staff to ensure more timely surveillance data is available.

The effectiveness of the Infection Prevention and Control (IP&C) system is regularly reviewed by the THPH Infection Control Committee and THPH Executive.

Managing patients with infections or colonisations

Guidelines for standard precautions and transmission based precautions are available for all clinical and non-clinical staff. There is evidence of staff training and compliance monitoring of both standard precautions and transmission based precautions.

This monitoring is restricted to an annual systems and equipment audit the results of which are regularly 100%. ICC involvement in overseeing the implementation of standard and transmission based precautions appears to occur however there is no data to demonstrate staff compliance with practice. Whilst the need for transmission based precautions rarely occurs it is suggested that processes for random observational audits be undertaken daily for the duration these precautions are in place, to support staff practice. Equally important is that this same process for random observational audits of standard precautions be undertaken, documented and used to enhance staff compliance with best practice.

Completion of the pre-admission patient information form ensures that patients with an infection or colonisation are identified to facilitate appropriate patient placement on admission and transfer. The WebPAS electronic system available in all clinical units identifies patient's requiring transmission based precautions.

Antimicrobial stewardship

The Antimicrobial Stewardship program has been enhanced considerably through strong clinical leadership and expertise of the recently appointed Director of Medical Service. There is now a standalone local policy that supports VMOs, pharmacists and nursing staff in prescribing and administration of antimicrobials through a MAC endorsed three class antibiotic traffic light system and access to a second Infectious Disease VMO consultant as required. Therapeutic Guidelines are available in all clinical areas.

THPH Antimicrobial Stewardship Committee has been established and will continue to report into the Infection Control Committee and MAC.

National Antimicrobial Prescribing (NAP) audit results for 2015 and 2016 demonstrate increasing compliance with therapeutic guidelines.

Cleaning, disinfection and sterilisation

Policies and procedures for environmental services are available to ensure the principles of infection prevention and control are practiced in cleaning, waste management, on site domestic type laundry and linen transportation, processing and storage. Clinical cleaning schedules as well as environmental cleaning schedules are well established. Clean utility areas and clinical store rooms have been enhanced through the installation of wire storage systems which is current best practice. The HICMR Facility Wide Environmental audit in 2015, 2016, and 2017 indicate 96%, 98% and 99% compliance. Similarly, a linen management audit for the same three years demonstrates greater than 90% compliance. Current material data sheets are readily available to staff.

A Gap Analysis to determine the current level of compliance with AS/NZS 4187:2014 for this subacute Mental Health and Rehabilitation Hospital has been undertaken and well documented. A corresponding detailed implementation plan has been developed and completely actioned. Consequently, action 3.16.1 has been rated as SM.

Evidence of training schedules and attendance records confirm staff allocated responsibility for the cleaning of medical devices in clinical areas are appropriately trained. Ward/ Gym based cleaning schedules were sighted during survey.

Communicating with patients and carers

The "My Healthscope" website provides public access to THPH Clinical Outcome performance for infection rates and hand hygiene compliance rates of staff and doctors.

Appropriate brochures are available for patients and families on the management and reduction of healthcare associated infections. Appropriate signage in lifts, corridors and public places prompts visitors to wash their hands and use appropriate cough etiquette. Hand hygiene stations are strategically positioned to encourage hand hygiene. Patient and consumer feedback on the usefulness of provided information is sought and used for improvement.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Action 3.1.2 Core

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

Surveyor Comment:

Since the last survey a risk management approach has continued to be undertaken to monitor the use of policies, procedures and/or protocols. A total of eleven annual Infection Prevention and Control audits are undertaken by HICMR that include Facility Wide, Allied Health Therapy Services, the Rehabilitation and Mental Health clinical wards, Linen Management, Environmental Services, Food Services, Hydrotherapy Pool, Maintenance and Staff Health. Each audit has consistently achieved a greater than 90% compliance from 2015 to 2017 with the range being from 90-99%. All identified opportunities for improvement are clearly documented in specific Action Plans. Evidence sighted during survey confirms that the majority of actions have been completed and closed. The survey team consider this outcome is exceptional and accordingly an MM rating is achieved on this action.

Surveyor's Recommendation:

No recommendation

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	MM
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 3.6.1 Core

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

Surveyor Comment:

The workforce immunisation program is well-established at THPH with sighted documentation confirming that 100% of staff have provided evidence of their vaccination history for Hepatitis B, Measles, Mumps, Rubella, and Varicalla. This consistent and sustained outcome is impressive and accordingly an MM rating is achieved on this action.

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

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

Surveyor Comment:

One-hundred percent (100%) of relevant staff have undertaken training and been competency assessed in aseptic technique. Consequently this transitional action is fully met at SM level.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

A completed Gap Analysis relevant for a Rehabilitation and Mental Health service has been undertaken and the related implementation plan developed. This implementation plan has been fully completed at the time of survey, therefore this action is satisfactorily met.

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

Corporate and THPH policies consistent with national and jurisdictional requirements are in place for governance and safety in medication. HSP is the contracted pharmacy service for THPH. Services provided include an on-site clinical pharmacist for patient reconciliation, regular audits and analysis of the National Inpatient Medication Chart (NIMC), and Medication Safety Self-Assessment (MSSA) review of patient NIMC, medication storage and patient and staff education. Medication incidents are monitored and reported monthly through the Medication Safety Committee. Systems and processes are in place to verify VMO, CMO, pharmacy and clinical staff authority to prescribe, dispense and administer medicines.

Documentation of patient information

THPH has very good processes in place to document medication history on admission and ongoing administration of medications. Allergies and adverse reactions are documented and noted both within the patient record and through the use of the alert red name band. Documented evidence provided included annual audit since 2014 of compliance with requirements of the NIMC and the MSSA audit results. Relevant action plans have provided opportunities for improvement across the medication management system. Examples of improvement following the 2015 and 2016 MSSA audit included revision of reconciliation processes and an increase the clinical pharmacist role to 22 hours per week have resulted in ongoing improvements in medication safety.

Medication reconciliation and discharge medication for high-risk patients is undertaken by the clinical pharmacist.

It was noted during survey that the recently implemented NSW DOH revised Dangerous Drug Registers that now require a staff signature and printed name for both the administering and checking person, are in place. Full compliance with this new state requirement has yet to be achieved by some staff continually using their initial instead of the required signature, contrary to legislation requirements. Immediate corrective action, including an ongoing monitoring process, was undertaken during the period of survey to address this issue.

Medication management processes

Required information and decision making tools are available in all clinical areas. Temperature storage is monitored well. The disposal of unwanted and out-of-date drugs including dangerous drugs is done appropriately. Each clinical unit has an appropriate Dangerous Drug safe/ cupboard. Mental Health administration of medication is undertaken for individual patients, by clinical staff through a coded access treatment room. It is noted that patients in rehabilitation have locked bedside drawers for the storage of prescribed medication and are opened by nurses for medication administration.

Recent analysis of reported medication incidents indicates a decreasing trend in reporting over a number of years. At the time of survey steps were being undertaken by the executive and the contracted pharmacy to strengthen the reporting culture in relation to medication related near misses and actual incidents which is encouraging.

Compliance with having 24 hour phone orders signed by the medical prescriber has improved significantly from 78% compliance in 2015 to 100% compliance in 2016- 2017.

Continuity of medication management

Clinical handover processes for patients on discharge or transfer involves the use of the Medication Management Plan and the patients NIMC for reconciliation of medication changes that have occurred throughout the patient's admission. A copy of the patients current NIMC is attached to the documented transfer summary accompanying the patient. A HSP generated discharge medication list is provided to all discharged patients.

Communicating with patients and carers

Evidence of patient education prior to discharge was clearly evident. This information which is relevant to both patient and their carer is clear and concise with patient feedback confirming high degrees of satisfaction with both pharmacist and staff education and support.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation: Hills Private Hospital, The
Orgcode: 125984

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Patient identification is well developed within THPH with the use of the Healthscope required four identifies. A Zebra machine, which is linked with the WebPAS, producers the patient identification arm band. The use of three identifiers of these Healthscope approved identifiers, namely patient's full name, date of birth and Unique Identifying number was obvious in clinical handover and patient identification situations observed during survey. Mental Health patients have photo identification in addition to the patient identification band, the latter being essential for medication administration. Audit results indicate good compliance however if a mismatch of patients does occur, it is quickly identified and rectified. The reason for the mismatch is sought, identified and actioned to ensure no further issues are found that lead to the mismatch. A near miss or incident is required to be entered into RiskMan.

The processes of identification checking are explained to patients and family on admission to assist their understanding of why this is constantly being completed.

Processes to transfer care

Patients spoken with by the survey team stated that they often had name bands checked and were frequently asked their name and date of birth to ensure correct person. The surveyors observed this process in action, both at clinical handover and prior to being escorted to the gym for therapy.

Processes to match patients and their care

Documented process and regular compliance monitoring is in place for matching patients to their care and throughout the continuum of care which include the use of handover checklists, medication management, discharge summaries and communication with GPs and other relevant community health providers. Compliance audits are regularly undertaken and results reported to managers and staff, the executive and the Quality Committee.

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

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

Local clinical handover practice is informed by Healthscope corporate policies that are formally reviewed every three years. Auditing of THPH clinical handover practice consistently identified specific areas for improvement and eight weeks prior to survey an impressive quality improvement project was initiated that involved a major change in practice for the three rehabilitation units. There is now a daily interdisciplinary meeting involving clinicians from all Rehabilitation units that utilises a new function in WebPAS that has been successfully piloted at Sydney Clinic. Information on the health status of every patient is projected onto a screen and changes made with input from nursing and allied health attendees.

Clinical handover processes

Bedside handover is undertaken once every 24 hours at change of shift across all clinical units. In the rehab units, this occurs at 2.30pm for rehab bedside handover and 3pm for MDT rounding. Bedside handover is typically a challenge in mental health units given that the patients are rarely in their bedrooms. The surveyors were impressed with local protocol that resulted in approximately 50% participation of mental health patients in bedside handover. A suggestion was made about introducing a new protocol to facilitate increased participation that involved the patient being consulted on a one-to-one both before and after the afternoon clinical handover. In the rehabilitation units bedside handover now involves the nurse in charge updating the WebPAS patient information database utilising recently purchased ipads.

Six monthly audit results and RiskMan incident data associated with clinical handover are routinely reported to the Standard 6 Working Party and Quality Committee as well as corporate committees.

Patient and carer involvement in clinical handover

The corporate policy on Clinical Handover dictates the involvement of patient and, where appropriate and with the patient's consent, the carer in the clinical handover process. The Patient Compendium contains a section informing the patient of this expectation. The mental health ward had developed a local brochure that requires patients to inform staff if they do not wish to participate in the formal clinical handover process. Ninety-nine percent (99%) of clinical staff have completed an online learning package on Clinical Handover and this has resulted in significantly increased patient participation as a result of staff encouragement.

The annual patient satisfaction survey includes questions related to clinical handover and a high level of satisfaction with the process is evident.

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

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

Healthscope policies and procedures are consistent with national evidence-based guidelines for the safe and appropriate, administration and management of blood and are regularly monitored at THPH. There is an active haemovigilance committee which includes the off-site pathology provider at Norwest Hospital. The prescribing and clinical use of blood is monitored and regularly audited to ensure compliance with national guidelines. Risks associated with blood use are identified and minimised as much as possible. Incidents and near misses are required to be reported through the RiskMan incident reporting system. There is no blood fridge within THPH. Accordingly, blood is supplied from the blood service at Norwest, a single unit at a time using the cold chain methodology. There are 10 to 12 units of blood transfused over a period of a year. In recent years, the use of iron infusion as an alternative to blood is trending higher.

Given the small and decreasing number of required blood transfusions in recent years, a detailed risk assessment has been undertaken to reduce the potential of risks associated with the ongoing clinical use of blood. The outcome of this in-depth review has determined that only packed cells would be transfused at THPH per week day and only during the 9am to 5pm time period. Key senior registered nurses (18RNs) were identified to undertake intensive training and competency assessment in blood administration. All blood transfusions are now required to be administered by one of these key RNs.

Every blood transfusion is recorded in RiskMan, providing a record of each event. All blood administration episodes are audited, reviewed and evaluated in accordance with policy and protocol, and a report documented for the Quality Committee and MAC. Nil adverse events have been recorded in the transport, or administration of blood transfusion following the implementation of this protocol.

Documenting patient information

All patients admitted to THPH have an admission assessment undertaken that includes a detailed review of the patient's blood transfusion history. A blood transfusion documentation pack has been developed to include all the Healthscope Blood Transfusion documentation for consent and administration of blood in addition to the patient information and explanation prior to completing their consent. Patients prescribed a unit of packed calls are scheduled for a predetermined time to coincide with the delivery of blood from the blood service. Travel time for the transportation of blood has been assessed and deemed to be at 15 minutes maximum time. By the time the blood is temperature checked into THPH reception desk and received by the administering RN the patient has is already cannulated allowing the patient identification and blood checking process commence immediately.

Managing blood and blood product safety

In addition to the specific senior registered competency training and assessment referred to above, all clinical staff are required to undertake the Blood Safe eLearning module. Staff has access to the Flippin Blood Resource for reference. Staff involved in the transporting of blood is full trained in the transportation of blood.

Appropriateness of blood prescriptions is reviewed for all episodes of blood transfusion with results reported to the Quality and MAC Committees.

In the last three years, there have been no adverse events associated with blood transfusion.

Communicating with patients and carers

Nationally recommended patient brochures and information are provided to patients and/or their carer. These are also available to relevant languages to meet the demographic requirements.

Informed consent is documented on a comprehensive Healthscope Blood Consent Form which remains in the patient's clinical record and audited following every transfusion episode.

Patient satisfaction surveys results are positive.

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	MM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Action 7.2.2 Core

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

Surveyor Comment:

A significantly low number of blood transfusions are performed at THPH indicating potential for risk. Consequently, a detailed risk assessment process has been undertaken since the last survey to reduce the potential risks associated with transfusion practices and the clinical use of blood. The results of this risk assessment and associated risk mitigation include a decision made that only packed cells will be transfused in THPH. All transfusions are scheduled Monday to Friday during business hours. Eighteen (18) key senior staff have undertaken intensive education and competency assessment in blood administration and are now responsible for all the administration of all transfusions. All blood administration episodes are audited and evaluated and the results reported to the Quality Committee. There have been no adverse events or clinical incidents associated with blood transfusion following the implementation of these risk migration strategies. The survey team consider this outcome is outstanding and accordingly an MM rating is achieved on this action.

Surveyor's Recommendation:

No recommendation

Documenting patient information

Ratings

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

7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

There is a strong proactive focus throughout THPH for the prevention and management of pressure injuries. Governance and systems are underpinned by evidence–based guidelines that inform the development of both Healthscope policies and local procedures.

The Waterlow Pressure Risk Assessment / Screening Tool for adult inpatients is used. Whilst all rehabilitation patients are required to have a visual skin integrity assessment on admission this is only required in mental health if the initial screening process indicates the patient is a high risk.

A very proactive multidisciplinary Preventing and Managing Pressure Injuries working party is responsible for overseeing effective governance across the organisation.

Regular audit results of hospital and community acquired pressure injuries are reported to the Executive and Healthscope as a KPI as well as being discussed at the Quality and Medical Advisory Committees.

Preventing pressure injuries

The Waterlow Risk Assessment is documented in the patient clinical record. The Management Plan to address the Waterlow score for each is located on the reverse side of the Waterlow Screen. Audit results indicate that patients are screened and assessed on admission and a Management Plan completed for all patients identified as being ‘at risk’. The prevention plan includes referral to the appropriate allied health team, and the provision of appropriate equipment and clinical care based on the Waterlow Score Prevention Strategies.

Both identified hospital acquired and community acquired pressure injuries are appropriately staged, documented in the clinical record, and reported as an incident in RiskMan. All hospital acquired pressure injuries are reported monthly to the Quality Committee. Pressure injuries stages 2 and higher are reported quarterly as Healthscope KPI and to the ACHS Clinical Indicator program.

In the last two years data analysis of all reported incident of pressure injury including hospital and community acquired identified that the majority of pressure injuries were identified on admission with lower incidents being hospital acquired. Hospital acquired Pressure Injuries were noted to be 18 in 2014-2015 and 14 in 2015 -2016. This data and a review of equipment and current bed mattresses in addition to the number of hired pressure relieving mattresses in July 2016 resulted in a decision to purchase density foam mattresses appropriate for patients with a Waterlow Score up to 20, with an additional higher grade pumpless air mattress for the current patient demographic identified as having a greater than 20 Waterlow score. The incidence of hospital acquired pressure injuries continues to decrease with only two reported from July – Sept 2017. Both cases have been clinically reviewed by the working party and causative factors identified which are being addressed through continuous improvement strategies.

Managing pressure injuries

Management of both pressure injury and wounds is consistent with evidence–based guidelines, namely the Pan Pacific Guidelines which have now been incorporated into the Prevention and Treatment of Pressure Ulcer Clinical Practice Guidelines Collaborative with the UK and Europe.

It is pleasing to note THPH staff were able to identify their ability to access these enhanced guidelines since the Healthscope Cluster procurement of same.

A wound management assessment and ongoing care form HMR 7.12 is used to document all wounds. Clinical staff appeared to be well informed about pressure injury management and wound management.

Communicating with patients and carers

Specific written information including the Clinical Excellence Commission Patient Information for Pressure Injury Prevention is available for patients on admission and discharge as required. Patient feedback indicates a high level of satisfaction with the information provided to them.

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: Hills Private Hospital, The
Orgcode: 125984

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation: Hills Private Hospital, The
Orgcode: 125984

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

Surveyor Summary

Establishing recognition and response systems

THPH has in place appropriate governance arrangements with respect to hospital-wide recognition and response systems. Local protocols are based on Healthscope corporate policies, guidelines and plans. The local committee overseeing clinical deterioration is the Clinical Management Committee that has key clinical managers as members. This committee reports to the Quality Committee and the Healthscope Clinical Deterioration Cluster.

The survey team acknowledge that THPH is a sub-acute facility and therefore patients are transferred to nearby Norwest Hospital when their deterioration requires advance care intervention. The organisation's response to clinical deterioration is multi-faceted and includes the onsite Medical Emergency Team (MET), operational from 8am to 8pm when the CMO is on duty, mandatory staff training in Basic Life Support and training in the appropriate use of the Patient Observation (Vital Signs) Procedure. There are approximately 16 MET calls (Code Blue and Acute Transfer) registered in RiskMan each month and each episode is subject to an internal review with staff able to confidentially access a contracted external EAP service if necessary.

There is a requirement that all staff are trained in basic life Support (BLS) and relevant staff are also trained in the utilisation of the Adult Observation Chart with rapid response "track and trigger”.

Management is congratulated on a recent initiative of having Clinical Nurse Educators from Norwest Hospital ED and ICU respectively conduct an in-service for nursing staff on the deteriorating patient and audits of the resuscitation trolleys. There are bimonthly audits of the resuscitation trolleys and this has achieved a sustained compliance rate above 95% for over 12 months preceding the survey. The Quality Committee and MAC both review the outcomes of all Code Blue responses. There has been only one death (expected) at THPH in the past two years.

Recognising clinical deterioration and escalating care

Appropriate utilisation as per policy of the Healthscope Adult Observation Chart is measured by audits undertaken every three months. Action Plans are initiated to address incomplete documentation.

There is a prominently labelled emergency response button located in every patient room and all patient activity areas. Each patient has an emergency call button at bedside but this is rarely used with only a handful of calls registered in the past 12 months. As reported above, all MET calls are reviewed for their appropriateness at peak committee level. There is mandatory annual clinical emergency response training for all staff. As a result of a HCCC complaint several years ago about clinical practice at THPH the standard frequency of clinical observations has been increased from daily to twice daily.

Responding to clinical deterioration

The criteria for a call for emergency assistance is explicitly defined in Healthscope policy. Emergency response is included in the hospital's orientation program. All emergency calls are reviewed to ascertain that they meet criteria. In the vast majority of cases auditing indicates they did.

The survey team was impressed with the organisation's achievement of 100% staff completion of online BLS training and 97% completion of online BLS competencies.

Medical staff is onsite from 8am until 8pm to provide Advanced Life Support if required after which the NSW Ambulance Service is contacted to transport the patient to Norwest Hospital.

Communicating with patients and carers

The Reach program is currently being rolled out across the hospital and an information brochure explaining the system is included in the Patient Compendium. Basically patients and their carers are prompted to ring 222 if they have concerns about an adverse change in the patient's condition. Reach is evidence-based and has been subject to significant evaluation by Healthscope corporate office prior to being introduced at THPH. Patient feedback suggests that the majority of patients have a good understanding of what to do if they have concerns about their health status.

Healthscope has a policy and information pamphlet on Advance Care Plans (ACPs). At pre-admission, there is a prompt about ACPs and if the presenting patient already has one it is updated and inserted in the Alert page at the front of the patient file. Not For Resuscitation Forms are completed by the patient with his/her doctor prior to admission and as with the ACPs inserted in the front of the patient file.

There have been substantial reports on the evaluation of MET calls and summaries of these reports were included in the July 2017 edition of the hospital's Quality Bulletin.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

The organisation provided evidence that 100% of clinicians had completed online basic life support learning with 97% completing basic life support competencies. This result is well above the benchmark set by Healthscope. The survey team verified that the specific requirements of this Action were fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Falls are the most frequently reported incidents at THPH and this is a reflection of the age cohort in the Rehab wards (Average age 79 years). Falls prevention and management strategies at THPH are informed by relevant corporate policies accessible on the Healthscope intranet (HINT).

Every patient admitted to THPH is assessed for their falls potential using the Falls Risk Assessment Tool (FRAT). Depending on their falls risk status, formal risk assessments are repeated on a weekly basis at a minimum. Those identified as being a high falls risk are promptly reviewed by the physiotherapist and the Occupational Therapist so that an integrated Falls Prevention Plan is developed. The Pharmacist also reviews these patients' medications and makes suggestions to the VMO re modification if it is considered that this would lower the risk of a fall.

There are six monthly corporate audits of FRAT utilisation complemented by alternate six monthly THPH audits of FRAT documentation (i.e. effectively auditing every three months). KPIs on the completion of FRAT within 24 hours of being admitted are benchmarked with THPH currently achieving 92%. All falls are required to be registered in RiskMan. Oversight is provided by the Standard 10 Working Party that reports to both the Quality Committee and the Healthscope Corporate Falls Cluster.

Online training in falls prevention and management is a mandatory requirement for all staff. RiskMan analysis reports identify contributing factors, outcomes, controls implemented and near misses. There are two ACHS Falls Clinical Indicators that are benchmarked and reported to the hospital Executive and Corporate Office.

The survey team was impressed with the range of interventions and initiatives introduced progressively to reduce the potential for falls. These include enhanced staff education and the purchase of a range of specialist equipment such as sensor mats and belts. The Exercise Physiologist has also recently introduced the Berg Balance Test that clearly demonstrates improved balance and therefore reduced falls risk resulting from her specialist intervention.

Falls status is included in all clinical handovers. Patient education is included in the Patient Compendium and in various posters placed strategically in the wards.

In the weeks preceding survey a Falls Safety Huddle was introduced for patients immediately after a fall. This is an interdisciplinary meeting with the patient aimed at identifying the cause of the fall. A number of quality projects have been implemented to reduce the potential for falls using trended data identifying the most likely time and place falls occur.

An equipment register is now maintained that includes all equipment and aids available to prevent falls. Included are high/low beds, grip socks and mobility aids.

Screening and assessing risks of falls and harm from falling

FRAT an evidence-based falls assessment tools is used. All patients are assessed for falls prior to admission. The most recent audit indicated 92% of patients had a completed FRAT within 24 hours of admission.

Preventing falls and harm from falling

The FRAT contains a multidisciplinary falls prevention and harm minimisation plan that is documented and inserted in the patient's medical file. Implementation of the FRAT Plan is monitored at clinical handover, at clinical review meetings and now at huddle meetings.

The survey team acknowledges that staff are using every resource available to reduce the potential for falls. However, the rate has only marginally decreased over the past three years. It is therefore suggested that staff consult with facilities that appear to have significantly reduced the frequency of falls.

The hospital conducts a Falls Prevention Day every six months.

Discharge planning involves the OT conducting a home assessment, the physiotherapist providing an individualised home exercise program and referral of the patient to ACAT and/or other community providers. There is an audit of discharge plans every 12 months to assess, amongst a range of issues, that appropriate interventions had been undertaken, that the referral was appropriate and that a home assessment was conducted. Many patients return to the hospital to attend the hospital's Outpatients Program that attracts between 30 and 80 participants each day.

Communicating with patients and carers

There a range of patient information documents available for patients from Healthscope (eg Keeping A Step Ahead Of Falls) and NSW Health that complement the locally developed Getting Up Staying Up brochure. These documents have been reviewed and endorsed by Consumer Representatives.

Patients are involved in the development of their respective Falls Prevention Plan with the latest audit indicating a 100% rate for patient signatures.

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

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: Hills Private Hospital, The
Orgcode: 125984

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Hills Private Hospital, The
Orgcode: 125984

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	MM
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	MM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	MM
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	SM	SM

	• surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	MM
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	MM
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	SM	SM

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

patient harm and increase the quality and effectiveness of medicines use

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	SM	SM

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their	SM	SM

carer in clinical handover are in use

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	MM
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

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Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

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Preventing pressure injuries

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

Managing pressure injuries

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

Communicating with patients and carers

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

	with patients and carers

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

	processes

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation: Hills Private Hospital, The
Orgcode: 125984

Recommendations from Current Survey

Not applicable

Organisation: Hills Private Hospital, The
Orgcode: 125984

Recommendations from Previous Survey

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

Recommendation: NSQHSS Survey 1114.3.10.1

Recommendation:

Ensure all relevant clinical staff undertakes ANTT training and competency assessment.

Action:

1. Risk assessment completed and not deemed necessary for mental health staff members due to infrequency of dressings required. Rehab staff will be called upon to complete or attend any dressings necessary within the unit.
2. mandatory education allocated to all relevant rehab nursing staff via elearning and elearning stats reviewed quarterly by nurse educator and reported on as quality KPI.
3. NUMs responsible for chasing up uncompleted elearnings for all staff members
4. Practical competency program underway with Nurse educator to ensure completion of competency with all relevant rehab nursing staff.
5. target to get to is 92% by Dec 2016
6. as of August 2017 94% of required staff have completed the competency for ANTT - if not yet deemed competent cannot undertake dressings in the hospital
7. Nurse educator to enlist help of designated CNS or Snr staff to assist with completion of competencies for staff. -
7a. Additional Clinical Nurse educator employed within hospital to help educate staff - September 2016
8. Stats regularly reported at infection control committee meetings - trending report will be available to surveyors at time of onsite accreditation.
9. reported progress on action plan at Quality quarterly basis.

Completion Due By: December 2015

Responsibility: Karen Kelly Infection control manager

Organisation Completed: No

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

Significant work has been undertaken to ensure that relevant staff have completed ANTT training and their competency assessment. Accordingly, this recommendation is closed.

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

Standard: Preventing and Managing Pressure Injuries
Criterion: Communicating with patients and carers
Action: 8.10.1 Pressure injury management plans are developed in partnership with patients and carers

Recommendation: NSQHSS Survey 1114.8.10.1

Recommendation:

Provide evidence to demonstrate that pressure injury management plans are developed in partnership with patients and carers.

Action:

Action Plan devised by the Hospital Pressure Injury Prevention Working party

1.Signature of patient on Pressure Injury form HMR7.5 as evidence that they have been involved in the discussion of their pressure injury prevention treatment plan.
2.As per corporate policy 8.05 Pressure injury - prevention, identification and management of, all patients are assessed for risk of Pressure injuries, and skin integrity on admission and updated thereafter. the final assessment is completed at discharge or transfer.
3.Education of staff at ward meetings about Pressure injury prevention and identification processes
4.Using whiteboard to aid in Pressure injury processes. Documentation of Pressure injury on patients information board to remind patient, damily members and all staff of existing Pressure injury or risk.
5. Use of a prompting poster in rooms if patient is at risk of Pressure injury (implemented July 2017)
6.Audit documentation on admission of patient involvement in their pressure prevention care plan -
7.Plan monthly working party meetings from Sept 2015 (increased from quarterly to monthly) - still ongoing
8. Allocate Pressure Injury champion via riskman so able to review all pressure injurys identified within the hospital as they are reported on
9. Education to be completed at ward meetings either by the NUM or member of working party- done and to be scheduled regularly throughout the year.
10. Completion of Corporate Audit - Facility - Pressure injury Prevention audit which reviews current policies and process in place within the hospital. this occurs 6 monthly. 95% compliance with policy directives, individual ward action plans established following this result.
11. completion of the pressure injury prevention patient audit - which includes a section where patients are surveyed to see whether they feel that they were adequately involved in the development of care plans around pressure injury prevention. - to be conducted a minimum of yearly, more frequent dependant on results of audit.
12. File audit conducted to review patient involvement in care planning for pressure injuries - 92% of the files audited showed clear documentation of discussion and involvement of patients in their care in regards to pressure injuries.
13. revision of patient handout with options reviewed and approved by Consumer Consultant and included with every patient compendium.

Completion Due By: July 2017

Responsibility: Sandra Essey PI working party

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

Organisation Completed: No

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

Significant work has been undertaken to ensure that every patient identified on admission as being a high risk of pressure injury according to the Waterlow Assessment tool has a pressure injury management plan developed in partnership with the patient and/or care. Accordingly, this recommendation is closed.

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

Standards Rating Summary

Organisation - NSQHSS V01

Core

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

Developmental

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

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

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

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

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

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: Hills Private Hospital, The
Orgcode: 125984

Surveyor - NSQHSS V01

Core

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

Standard	SM	MM	Total
Standard 1	41	3	44
Standard 2	4	0	4
Standard 3	37	2	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	19	1	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**203**	**6**	**209**

Developmental

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

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	10	1	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	**46**	**1**	**47**

NSQHSS Survey

Organisation: Hills Private Hospital, The
Orgcode: 125984

Combined

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

Standard	SM	MM	Total	Overall
Standard 1	50	3	53	Met
Standard 2	14	1	15	Met
Standard 3	39	2	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	22	1	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**249**	**7**	**256**	**Met**