Report of the ACHS EQuIPNational Interim Accreditation Survey

Northern Beaches Hospital

Manly, NSW

Organisation Code: 12 69 24

Survey Date: 7 - 9 November 2018

ACHS Accreditation Status: **Interim Accreditation**

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

The action numbering relates to the month and year of survey and the action number. For example, recommendation number OWS 0613. 1.1.1 is a recommendation from an OWS 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 : Northern Beaches Hospital
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Survey Report

Survey Overview

EXECUTIVE SUMMARY

Northern Beaches Hospital (NBH) is a 488-bed acute hospital succeeding the previous services of the Manly and Mona Vale Hospitals, in a Public-Private Partnership (PPP) between the New South Wales government and Healthscope Ltd. Opened in late October 2018, NBH underwent onsite Interim

Accreditation assessment against EQuIPNational by a team of assessors on 7-9/11/2018.

EQuIPNational is an integrated healthcare accreditation program which comprises fifteen Standards: the current ten National Safety and Quality Health Service (NSQHS) Standards, against which hospitals and day procedure centres are federally required to be accredited, and the five EQuIPNational Standards, derived from key elements of the EQuIP program and covering the performance of service delivery processes, provision of care and non-clinical systems. The integrated program was selected as preparation for future NSQHS Standards assessments.

At the time of the Interim Accreditation survey, evidence was provided that policies, processes and systems are in place to ensure care and services are delivered safely. The assessors were impressed by the level of engagement by Healthscope Corporate Office, the involvement of the consumers and volunteers, the education and training, the IT support and the equipment and resources provided for all staff and managers prior to and upon opening.

NBH demonstrated commitment and dedication in ensuring care and services are delivered safely to patients and the broader community. Robust leadership, a culture of improving performance, quality and risk management, staff education and training, as well as community engagement are embedded in every day practice.

Policies and procedures are in place. Processes to measure, monitor and evaluate care and services have been planned for implementation in a timely manner.

The latest technology and equipment has been purchased for clinical staff to ensure they are able to deliver patient centred care at the right time, in the right setting every time.

The Northern Beaches Hospital EQuIPNational Interim Accreditation process and successful assessment show continued commitment to deliver high quality care and services to the people of the Northern Beaches area.

Interim Accreditation

For health service organisations commencing operations, Interim Accreditation to the requirements set out by the Australian Commission for Safety and Quality in Health Care (ACSQHC) will generally apply for the first 12 months of operation. The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme requires health services with interim accreditation to undertake an accreditation review within 12 months of the interim accreditation assessment and the process is to be completed prior to the expiry date of the interim accreditation award.

EQuIPNational Interim Accreditation

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Each of the actions in the Standards are in one of the following categories:

1. Core: Actions that must be met to be accredited to the EQuIPNational and NSQHS Standards;
2. Developmental: Actions where activity is required, but does not need to be fully met to achieve accreditation; and
3. Non-applicable for 12 months: Actions which focus on audits, review or monitoring of system and will require a history of service provision before an organisation can gather evidence that demonstrates actions have been met.

Furthermore, some core and developmental actions are prescribed. This occurs for actions where patients or patient information is required, that may not yet be available because the operation is just commencing but should be undertaken during the 12-month period of interim accreditation.

Interim accreditation for a new health service organisation, as described, satisfies the requirement to be accredited to the NSQHS Standards for the purpose of achieving second-tier default benefit eligibility under the Private Health Insurance (Benefit Requirements) Rules 2011.

Summary of Findings

The outcome of the ACHS EQuIPNational Interim Accreditation survey for Northern Beaches Hospital conducted on the 7th, 8th and 9th of November 2018 confirms all core actions and mandatory criteria of the EQuIPNational Standards have been rated Satisfactorily Met (SM).

The assessment team recommends award of Interim Accreditation to Northern Beaches Hospital.

OVERVIEW

The assessment team was impressed by Northern Beaches Hospital's leadership, commitment and tireless efforts undertaken in preparation for their opening and preparedness for their Interim Accreditation.

Healthscope (HSP) Corporate Office clinical and corporate governance structures, policies, procedures and processes are in place.

Significant education and training of staff was apparent with over 2,500 staff trained in all clinical and support services.

Consumer engagement was of high priority and clearly evidenced by the design and graphics throughout the hospital. The volunteers who were there to meet and greet patients and visitors were warm and welcoming.

The challenges associated with commissioning a new hospital are acknowledged. The HSP vision and mission to deliver care and services safely to both private and public patients was evident.

The assessors also wish to acknowledge the managers and staff for their active participation during the survey.

The assessors appreciated the information provided prior to the interim survey and at the time of the survey. Evidence was available to support the hospital's self-ratings of Satisfactorily Met (SM) in all NSQHS Standards and EQuIPNational prescribed action items.

NSQHS Standards

1. Governance for Safety and Quality in Health Service Organisations

NBH demonstrates a culture of quality and safety across the hospital through their integrated governance system that actively supports and manages patient safety, quality and risks and the organisation is continuing to be responsive to improving safety and quality of patient care as services are fully operational. Processes of reporting, auditing, review and critical analysis and reflection were evident.

Clinical practice is evidence-based, and staff clearly understand their responsibilities. There are mechanisms in place to support the early identification, intervention and management of patients at increased risk of harm with relevant and appropriate systems to escalate the level of care in the event of unexpected deterioration.

The patient electronic medical record is well integrated and appropriate to good patient care. Further enhancements are occurring regarding the uploading of the existing hard copy medical record forms into the electronic platform.

Credentialing and Scope of Practice is managed in accordance with HSP policies and By-laws.

Performance and skills management is well done with appropriate systems in place to support, monitor and evaluate performance across all clinical and support services.

Staff education and training in respect of patient safety is of paramount importance and remains ongoing.

The system for managing incidents and complaints has been well planned and effectively managed across the hospital. Open disclosure policies and processes are in place and the clinical workforce has been trained

Patients' Rights and Responsibilities are respected and included in patient information guides, brochures, the website, in-house TV presentations and at the point of care.

2. Partnering with Consumers

NBH has demonstrated a notable partnership with consumers with the establishment of the Consumer Advisory Group (CAG) three years before the opening of the new hospital, with thousands of individual and group consultations, to ensure that community input and feedback was incorporated into the hospital's overall design, access and functionality. Consumers are also involved in all levels of governance and provide feedback on all patient information and review the patient experience survey results.

3. Preventing and Controlling Healthcare Associated Infections

Preventing and Controlling Healthcare Associated Infections is evident in all clinical units and support services. The new hospital is beautiful, spacious and conducive to good patient choices and care. The dedication and commitment by the Infection Control Committee to ensure all infection control systems were in place and all tested prior to the opening, is to be congratulated.

4. Medication Safety

Medication Safety is comprehensively managed, with an enthusiastic and expert governance committee providing leadership. The HSP Cluster Committee and “Shared Learnings”, as well as the EPIC pharmacy external provider “Topic of the month” provide additional support for safe prescribing, administration and dispensing. The extensive clinical pharmacist network within NBH provides a valuable resource to manage risks.

5. Patient Identification and Procedure Matching

There are thorough processes for patient identification and procedure matching evident in NBH, and the extensive audits that are scheduled will identify opportunities and further enhance patient safety.

6. Clinical Handover

Clinical Handover is multidisciplinary with good local processes and standard handover checklists developed in collaboration with clinicians, patients and carers.

7. Blood and Blood Products

Governance of blood and blood product safety is provided by the NBH Pathology and Transfusion Committee, and the HSP Cluster Committee. Laboratory Haematologist expertise is currently provided to the Committee remotely, but it is anticipated that haematologist support will be provided onsite in the near future. Prescribing and supply systems are comprehensive and will be audited by a comprehensive audit tool.

A massive transfusion incident was well managed within the first week of operation of NBH.

8. Preventing and Managing Pressure Injuries

The prevention and management of pressure injuries is overseen by the HSP Pressure Injury Prevention working party who ensure that evidence-based procedures and assessment tools are used effectively. NBH has developed a comprehensive audit system and audit calendar schedule that will assess compliance against the pressure injury policy.

9. Recognising and Responding to Clinical Deterioration in Acute Health Care

Skilled, caring and responsive staff are well trained and educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient’s health status.

10. Preventing Falls and Harm from Falls

The prevention and harm from falls is governed by the HSP Falls Prevention Cluster. Procedures and assessment tools based on best practice guidelines are in place. The comprehensive audit system and audit calendar schedule has been introduced to assess compliance against the falls prevention & management policy and the falls risk assessment & management tool.

EQuIPNational Standards

11. Service Delivery

Service delivery for NBH has been a major focus that began with the establishment of the CAG. The process of informing consumers, with the patient information guide being a highlight. NBH has adopted and is utilising HSP consent processes effectively. A Clinical Panel is involved in identifying service delivery requirements.

The Medical Advisory Committee (MAC) has contributed significantly to recruiting and credentialing medical specialists and they are now working with individual clinical departments to establish formal peer review processes and morbidity & mortality meetings.

12. Provision of Care

HSP's evidence-based best practice assessment guidelines and tools have been developed and implemented as well as a comprehensive suite of audits to measure compliance. Care planning is well covered from admission through to discharge or transfer of care.

Nutrition is well managed in accordance with HSP policies and Hazard Analysis and Critical Control Point (HACCP) food safety guidelines. NBH has flagged that they are considering a trial of `protected meal times', which would greatly enhance the patient experience and contribute to improve nutritional outcomes.

13. Workforce Planning and Management

NBH has a comprehensive Workforce Plan and policies and procedures are in place for recruitment, selection, employment and development and employee support. A workforce profile was developed to meet the needs of the clinical and support staff based on the commissioning and opening of the hospital.

A Medical Advisory Committee managed the credentialing of new medical staff. NBH has systems to manage personnel records securely. A range of templates and tool kits are available to assist managers with Personal Performance Review (PPR) processes.

14. Information Management

The HSP organisation-wide health records management system has been implemented. Patient records are tracked using the WebPas system. NBH has an Information Management and Technology (IM&T) project plan and robust Information and Communication Technology (ICT) interrogation systems that are continually monitored.

The security of the Information Management and Technology (IM&T) systems is managed by the HSP Security Manager and Cyber expert.

15. Corporate Systems and Safety

The HSP Strategic Objectives Plan provides overarching vision, goals and direction. The NBH Strategic Plan is currently being updated following the hospitals commissioning.

A clinical governance system is in place to manage clinical practices, clinical staff education and competencies.

A Quality Safety Plan and improvement processes are in place to ensure the effective management of delegations, external service providers, safety management systems, buildings, plant and equipment, emergency and disaster management as well as physical and personal security.

NBH is commended for their good work and their achievements in light of such an enormous undertaking to manage the commissioning of this “State of the Art” facility.

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

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STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

As a HSP hospital, NBH has implemented and works within the HSP overarching long established and effective governance and quality improvement systems. The NBH Quality & Safety Plan reflects the requirements of the HSP plan and addresses the requirements of the NSQHS Standards for Interim Accreditation. Policies, procedures, guidelines, project plans and standard operating procedures (SOP) have been established to enable commencement of operation of the new NBH. All documents are available for staff to access via the NBH intranet site HINT. All policies and procedures (PP) and HSP and NBH documents are managed and reviewed by the HSP Document Controller.

The NBH organisation structure and associated committees have established the mechanisms and templates that will ensure that patient safety and quality care will be considered in all business decision making processes.

Workforce delegations have been allocated and all position descriptions outline delegation and safety and quality roles and responsibilities. One hundred percent (100%) of all new staff have been orientated to understand their roles and responsibilities.

NBH has an accredited Health Education Training Institute (HETI). The simulation of real life scenarios and the investment of equipment and technology to support this real-life environment is to be congratulated. The assessors when visiting HETI were able to observe scenarios and see staff undertaking training. There is a General Clinical Training Committee that oversees ongoing education and skills development opportunities.

The HSP organisation-wide risk management system (RiskMan) has been implemented at NBH. Staff receive training during orientation on how to use RiskMan to report and manage risks. Risk reports will be provided to HSP and NBH executive committees as set out in the reporting schedules.

A NBH organisation-wide quality management system has been established and aligns with the HSP Safety & Quality Plan.

Clinical practice

NBH has a suite of clinical competency assessments. Ongoing mandatory clinical practice review is a component of the audit schedule. A register is in place to record which staff have completed their mandatory training. Staff from Manly and Mona Vale who were transferring to NBH were required to undertake education and training on-site at NBH.

A total of 2,500 staff were trained prior to the opening of NBH this included a number of staff transferred from Manly and Mona vale as well as newly recruited staff. The staff database included a total review of staffs profiles their current qualifications and experience and availability to work in the unit or department. The intense work took over 6 months in collaboration with industrial bodies and individual staff members.

When visiting the clinical departments vital equipment such as, emergency trolleys were readily available. The ICU, CCU, HDU, Interventional suite and cardiac catheter labs were extremely well equipped with new equipment and “State of the Art” technology.

HSP evidence-based clinical guidelines are available to staff via the HINT intranet site. Clinical policies and procedures Policies and procedures are current. The HSP Critical Systems process is used to evaluate agreed clinical guidelines.

At admission, staff will use patient risk assessment tools to do a comprehensive patient risk assessment. Identified risks will then be used to inform their individual care plan. NBH policy requires that patient risks are to be discussed at each clinical handover.

Clinical records are generated in both the electronic Medical Record (eMR) and hard copy. Hard copy information will be integrated into the eMR after discharge. The WebPas system is used to track clinical records and will inform auditing processes. All staff have computer access and are taught how to use it at orientation and as needed.

During the assessment visit to a patient care ward, it was noted that the patient record was hanging on the handrail outside each patient room. While the patient details were not visible to people passing by, the paper record in some instances was found to be ripped and this could expose patient personal information. Another issue caused by this practice is that people requiring the use of the handrail were having their way blocked by the hanging patient record.

It is suggested that this practice be reviewed, and an alternative system be sought to ensure patient charts are secure, patient confidentiality is maintained and accessible so that clinical staff are able to access the record in a timely way.

Performance and skills management

The system to be used at NBH to determine and regularly review the roles, responsibilities, accountabilities and scope of practice of the clinical workforce is based on the HSP policies and procedures and By-laws. NBH has a Medical Advisory Committee (MAC) that is responsible for the credentialing and re-credentialing of medical specialists. Processes are in place to monitor credentials management and scope of practice compliance.

The HSP system for performance appraisal, individual professional development plans, ongoing education, competency assessments and feedback processes will be used at NBH to ensure the clinical staff have the skills and knowledge necessary for providing quality safe clinical care.

Incident and complaints management

RiskMan is the HSPs comprehensive organisation-wide incident and complaints management system. The system is used to capture complaints and incidents and provide a framework for incident and complaint reporting, risk analysis and rating, investigation, action plan development, improvement and outcome evaluation. Staff have been taught how to use RiskMan during their orientation to NBH. A system for regular reporting to HSP Board and NBH Executive, MAC and a system for providing feedback to NBH committees and staff has been developed. The system is already being used to report incidents, hazards and complaints.

Patient rights and engagement

HSP has a Rights and Responsibilities policy that complies with the Australian Charter that is now being used at NBH. Brochures and other information booklets are readily available to patients and carers.

During the interim survey, numerous examples of how NBH had consulted and involved the local community, various interest groups representing people with disabilities and diverse backgrounds were sighted. The feedback from the participants was used to inform decisions and make improvements.

EQuIPNational Interim Accreditation

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Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	N/A	N/A
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	N/A	N/A
1.5.1	SM	SM
1.5.2	N/A	N/A
1.6.1	SM	SM
1.6.2	N/A	N/A

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	N/A	N/A
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	N/A	N/A

Incident and complaints management

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

NBH has demonstrated a very strong focus on the engagement of consumers in service planning, dating back to 2015 in preparation for the commissioning of the new hospital. The Consumer Advisory Group (CAG) was established in April 2015 and has been instrumental in facilitating the consumer led engagement and communication strategy for NBH.

The introductory presentation by the NBH CEO to the assessment team identified early on the amount of work that has been done in partnering with consumers, especially in the service planning of the new facility. Prior to the opening of the new hospital, it was noted that there have been over 20,000 face-to-face consultations with community members and many more through organised hospital tours to over 5,000 people, community presentations to over 6,000 people and drop-in sessions for over 2,000 people. The regular communication strategies with the local community were so effective that they elicited over 300 applications for volunteer positions, of which only 100 volunteers were required during the initial opening period.

The NBH CAG demonstrated extensive consumer partnership by reaching out and engaging with a diverse range of consumer groups that included tours with oncology, renal and mental health patients, with their families and carers; a number of CALD & ATSI groups (indigenous naming of rooms & welcome to country); disability groups (i.e. Cerebral Palsy Alliance); and those with poor sight; all of whom were given the opportunity to test the access to and within the hospital, way-finding signage and the design of furnishings e.g. the height of admission and booking desks etc. Their combined feedback was collated and used to amend hospital design, furnishings and admission processes.

Consumers are actively engaged and involved in the governance of NBH with consumers included in all communication strategies and reviews. There is a policy `Consumers – Partnering with' which directs the Healthscope facilities on the level of consumer engagement required and details how this is to be done. The comprehensive engagement of consumers throughout NBH ensures that the patient and community perspective is always represented at all levels of the organisation. Consumers are very well represented on these very senior committees, including the NBH Patient Care Review Committee (PCRC), as well as having representation on the National Healthscope Cluster Committees being Quality, Consumer Participation & ATSI. There are also NBH specific policy documents that establish the inclusion of consumers within NBH which include the NBH Stakeholder Engagement and Communications Strategy; Community Engagement subplan; and the Consumer and Carer subplan.

Consumers are actively involved in reviewing all information provided to patients, including pamphlets & brochures, through the CAG that ensures that all information which will be provided to patients undergoes a rigorous process which includes seeking feedback from consumers as to the value of the information and whether the information is well displayed and easy to read. The Policy, `Consumer Approved Publications' details the consumer involvement required and it has also implemented a clear consumer approved recognition on all approved brochures called a Consumer Approved Publication (CAP) which is stamped on the front of all approved brochures. The assessors were very impressed with the involvement and *endorsement* of the comprehensive "Patient Information Guide" by the CAG which clearly demonstrates the engagement of consumers.

Consumer partnership in designing care

Consumers have been actively engaged and encouraged to provide input into the design and build of the new NBH for over three years before the facility opened. The CAG was established in April 2015 and they have clearly been involved every step of the way with input provided on everything in the new hospital from the artwork and graphics; the naming of roads and meeting rooms; and also the landscaping.

The assessment team saw a number of examples of how the design and function of some departments and public areas were influenced by the consumer representatives. The CAG members invited special interest groups into the hospital to test certain aspects of the design; including inviting the consumers of Cerebral Palsy Alliance to test the function of the facility for people requiring access with wheel chairs and also visually impaired consumers who were able to provide feedback to changes in lighting in the admissions area.

The NBH Patient Centred Care Model document clearly articulates the focus and the principles on ensuring that services and models of care are designed around the patient's needs. NBH has adopted these principles and integrated them into all aspects of their service provision including employee recruitment, education & training of the workforce, patient rounding & clinical handover and all their models of care.

Patient Centred Care (PCC) training is mandatory for all staff and compliance rates were very high in line with the opening of the clinical services in the hospital. The PCC training is included in the orientation program for all new staff and the orientation program includes a presentation session by a member of the CAG.

Consumer partnership in service measurement and evaluation

Pertinent information on the organisation's safety and quality performance is provided to the community, patients and carers through the main Web portal on the MyHealthscope Website. The comprehensive website provides the community and consumers with easily understandable and transparent information on the clinical and quality outcomes of the organisation.

The information includes clinical indicator rates for NBH which is benchmarked against other Healthscope Hospitals and includes timeline trending. The Website also includes information for the community and consumers on what the indicators are and how the information is collected; and also some additional resources that will help patients understand how to wash hands with a brochure and video made available online. The CAG is able to review this benchmarked data and review how NBH is performing against peer hospitals.

Processes and procedures are in place to ensure that consumers are involved in quality improvement activities and the consumers participate directly in these improvement activities through representation on the CAG.

The CAG is involved in the review and evaluation of all patient feedback data and this is implemented as per the Policy `Consumers – Partnering with' which also ensures that consumers are involved in quality improvement activities. The NBH Qualtrix Patient Experience Survey is emailed (or patients are provided with a hard copy if needed) after they are discharged, and the anonymous data is aggregated and can be further refined to provide dashboard reporting to NBH and at a Department level. Patient experience survey response rates, net promoter scores and overall satisfaction rates are key performance indicators measured on a monthly basis. The patient experience survey results are also reviewed by consumers at the PCRC and their feedback is then incorporated into any action plan that is designed to address the concerns raised.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	SM
2.1.2	N/A	N/A
2.2.1	SM	SM
2.2.2	N/A	N/A
2.3.1	N/A	N/A
2.4.1	SM	SM
2.4.2	N/A	N/A

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	N/A	N/A

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	N/A	N/A
2.8.2	N/A	N/A
2.9.1	SM	SM
2.9.2	N/A	N/A

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Infection control systems have been implemented in accordance with HSP corporate policies and procedures, the Australian Guidelines for the Prevention and Control of Infections in Health Care and the NSW Ministry of Health.

HICMR (Healthcare Infection Control Management Resources) Infection Prevention and Control (IPC) Policy Manual, Sterilising Services and Endoscopy Policy Manuals are available on line for staff to access.

The Infection Prevention and Control Committee Terms of Reference (TOR) have been established. The TOR has defined reporting items such as HSP Quality KPIs and the Hospital Acquired Complication (HAC) data. The membership is well represented by all services and department managers and led by the Infection Control Coordinator. The Infection Control Coordinator is a member of the National Infection Prevention and Control Cluster whereby evaluation and benchmarking occur.

There is also an Infection Prevention and Control (IPC) Management Plan Toolkit – Part B Annual Calendar as well as the RL6 Infection Control Surveillance Software Program.

The Infection Prevention and Control Risk Management Plan 2018/2019 (HICMR) is comprehensive and describes actions required, HICMR and NBH strategies as well as outcomes and recommendations. The Infection Prevention and Control Committee are the overarching body to ensure the Infection Prevention and Control Plan will be reviewed on a regular basis.

The risk management approach to infection prevention is highly impressive. RiskMan is the incident management system used and has defined descriptors regarding Infection Prevention Indicator sets.

Infection control surveillance Hospital Acquired Infections (HAIs) KPI Plan is monitored through pathology results, risk assessments and screening, incident reports and compliance audits. Food safety and cleaning audits are in place.

Monthly reports are a standing agenda item at the NBH Patient Care Review Committee (PCRC), the Executive Committee, the Medical Advisory Committee (MAC) as well as clinical and department meetings.

Healthscope has a good system in place to ensure Shared Learnings are distributed across all of its facilities and as such are extremely valuable for NBH to assess and review.

Infection prevention and control strategies

The Hand Hygiene Program Plan, deemed a high priority continues to be reviewed throughout all clinical and non-clinical areas, in accordance with the hospitals Hand Hygiene Management Plan and national hand hygiene guidelines. Staff education commences at orientation and regular information sessions are conducted internally and externally. Results from audits are being reported to the appropriate committees and service areas. Gold Standard Auditors have been trained and are commencing the 5 Moments observational audits in all clinical and non-clinical departments.

The availability of hand hygiene Alcohol Based Hand Rubs (ABHRs) at the point of care was discussed at the time of the interim survey. An action plan has been developed and it is suggested that the Infection Control Coordinator continue to monitor the availability of hand hygiene ABHRs at the point of care and especially in high-risk departments.

Staff screening, assessment against vaccine preventable diseases is a risk-based workforce immunisation program with clear guidelines and policies for all staff and all departments and services.

Records are required for all new employees and a database has been developed for staff transferring from Manly and Mona Vale based on staff profiles (RISK RATED)

Vaccine Preventable Disease (VPD) Evidence Certification Form is used to ensure staff have been screened for Vaccine Preventable Diseases such as TB, Hep B and C, Rubella Whooping Cough, Chicken Pox and influenza; a Panel Checklist is also used.

Mandatory training regarding notifications of infectious diseases and injury management of Occupational Blood and Body Fluid Exposure Incidents (BBFEI) have been conducted.

The Asepsis and Aseptic Non-Touch Technique-Program Plan has been commenced with staff on-boarding education and eLearning education provided. Compliance regarding the use of aseptic trays and IV medication administration has been implemented.

There is a raft of evidence-based policies and procedures regarding the insertion and management of invasive devices. Invasive Devices Audit, ANNT Audit, Environmental Audit and Personal Protective Equipment (PPE) audits are in place and include training of clinical staff in the Interventional Suite and CSSD, CCU, HDUs, and clinical departments such as Maternity and Paediatrics.

Mandatory training is captured on ELMO, the HSP education database.

Cold Chain policies are in place regarding temperature monitoring. Data loggers are also used in blood, vaccine and medication fridges which are also centrally monitored.

Managing patients with infections or colonisations

The NBH Project Infection Prevention and Control Plan is comprehensive with detailed design factors to ensure infection control is managed at the highest level of governance, inclusive of physical planning, negative pressure and specialised designed elements for departments such as ICU and the Interventional Suite.

Standard precautions and transmission-based precautions, consistent with national guidelines are in use. Precaution signs are readily available and are colour coded and easily understood. Alerts are also captured on the eMR, as well as validated screening tools.

It was noted at the time of the interim survey there was not enough PPE stations in the medical ward and a mobile station was borrowed from another department. This was brought to the attention of the Infection Control Coordinator who explained that another 20 had been ordered, also at the time the design was questioned. However, on talking to the staff it appears the staff had been consulted and that there is still an opportunity for the stations to be reviewed. A risk assessment is suggested to be undertaken regarding the number of PPE stations required as wards open and occupancy and demand increases.

The Clinical Audit Schedule is in place as well as the Preventative Maintenance Schedule, provided by the external contractor.

Catering and housekeeping cleaning schedules and food safety audits have been implemented and at the time of the interim survey appear to be very well managed.

Antimicrobial stewardship

The Antimicrobial Stewardship Program is underpinned by NBH policies and procedures. The Medication Safety Committee oversees the AMS Program. A traffic light chart has been implemented to monitor the prescribing and appropriate use of antibiotics. Clinicians are well engaged and are working closely with the microbiologists and pharmacists in this regard.

Therapeutic guidelines are available via the intranet (HINT) NAPS and National Antimicrobial Utilisation Surveillance Program (NAUSP) Audits are progressing.

Cleaning, disinfection and sterilisation

Maintenance, waste and linen are provided by external contractors. An external maintenance contractor was engaged in the building and commissioning project and continues to provide maintenance services to the hospital. As part of all the external contractors Service Level Agreement (SLA) a set of KPIs are to be reported monthly to the Executive.

HICMR Environmental Services policies and procedures are well established and well published.

Daily cleaning schedules for housekeeping and catering services are in use. Staff education has been of paramount importance and is ongoing. Cleaning trolleys are well equipped with standard products and PPE’s housed in compartments on the trolleys.

The hospital’s cleaning, disinfection and sterilisation practices meet all current AS4187 and GENCA guidelines.

“State of the Art” technology and equipment, as well as the design and layout of the Interventional Suite, CSSD and Endoscopy suite support and enable the well qualified staff to work safely and efficiently. The automated instrument tracking system Censitrak in CSSD is highly impressive. Instruments are bar-coded which allows verification of processes at each critical phase. The reprocessing of scopes is also diligently monitored and recorded.

Equipment education has been managed comprehensively in relation to the newly commissioned Washer Disinfectors, Pre-vacuum Sterilisers, Sterrad low temperature sterilisers, Ultrasonic and Chemical dosing, scope reprocessing and drying cabinets. Equipment manufacturers were on-site at the time of the interim survey to support staff and provide real time education.

Water testing of the cooling towers as well as Hepa-Filter air exchange compliance, negative pressure validation, dedicated refrigerator and freezer temperature calibrations were all installed and managed in accordance to manufacturers guidelines and building codes as well as jurisdictional requirements before the opening of the hospital. Stringent compliance audits are in place.

Communicating with patients and carers

It was evident at the time of the interim survey that the hospital has engaged with patients and consumers in relation to infection control prevention. There is specific consumer information regarding hand hygiene in respect to IV Access devices, Vancomycin Resistant Enterococcus (VRE) and Methycillin Resistant Staphylococcus Aureus (MRSA) in the Patient Information Guide.

Pre-admission and assessment tools also provide patients with information regarding risk factors and the management of infectious diseases.

Feedback is being sought. The hospital is encouraged to keep up the good work.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

It was evident at the time of NBH interim survey that an enormous amount of time and education has been conducted to ensure newly appointed clinical staff and clinical staff who transferred from Manly and Mona Vale have been trained in Aseptic Technique. The assessors also observed good practice in this regard when visiting the Critical Care areas and one of the newly opened medical wards.

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	N/A	N/A
3.11.4	SM	SM
3.11.5	N/A	N/A
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	N/A	N/A

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:

NBH as part of the commissioning of this new facility has purchased all new medical equipment, instruments and devices. The significant training and education undertaken by all the manufacturers for staff is impressive and was demonstrated to the assessors whilst on-site including the diligent monitoring of cleaning, disinfection and sterilisation of reusable instruments and devices. NBH is compliant with AS/NZS 4187 requirements.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	N/A	N/A
3.19.2	N/A	N/A

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Governance of medication safety is provided on-site by the multidisciplinary NBH Medication Safety Committee which reports via the NBH Patient Care Review Committee. The enthusiasm and expertise for medication safety amongst the clinicians on the NBH Medication Safety Committee is palpable. Currently one representative from NBH also sits on the HSP Medication Safety Cluster Committee and there is the opportunity to enhance the expertise of the Cluster Committee with further representation from NBH. There is a raft of medication policies and procedures that comply with legislative requirements and have been approved by the interim Committee. The outstanding issue of standing orders is currently being considered by the NBH Medication Safety Committee.

Incidents are reported and managed via RiskMan, which will guide NBH quality improvement projects. Further focus on medication safety is available through the HSP “Shared Learnings” and EPIC Pharmacy “Risk of the Month” programs.

Scope of practice is delineated for nursing staff, including endorsed enrolled nurses. There is mandatory annual medication eLearning programed. In regard to scope of practice for pharmacists, the ClinCat program of The Society of Hospital Pharmacists of Australia (SHPA) provides a supervision framework for pharmacy staff and a residency program is envisaged for junior pharmacists in the future.

A number of audits have been scheduled to review the medication management system including high risk medications audits and medication chart documentation audit.

Documentation of patient information

Clinical pharmacists on each ward assist with ensuring the best possible medication history for complex patients as identified by a risk assessment on admission. The medication management plan then guides medication reconciliation at all transfers of care.

Medication management processes

Decision support tools are readily available at the point of care and include MIMs online and Therapeutic Guidelines. Clinical Pharmacists are available on the wards for advanced requests for drug information. The Clinical Pharmacist service has been extended to weekends which is an excellent initiative.

Storage of medicines in the wards is secured by swipe access into the Clean Utility Room. There is an opportunity to review storage of medications in several units, like ICU, ED resuscitation area and the Birthing Suite.in particular relating to the location of the drug cupboards that were housed in the nurses’ stations. A review of these locations was being conducted at the time of the interim survey

High risk medications have been defined by the Medication Safety Committee and the drugs included on the high-risk register include APINCH, some antipsychotics and neuromuscular blocking agents. The register will be reviewed annually.

A sophisticated dispensing system in pharmacy minimises the risk of unused or expired stock and contributes to safe dispensing. The packaging format of some drugs is not compatible with the dispensing machine and manual procedures are in place for the safe storage and dispensing of these drugs.

Continuity of medication management

There is mandatory reconciliation of medications at discharge, with printed lists given to patients and emailed or faxed to the patient's general practitioner (GP). Discharge summary completion rates is a HSP quality KPI which satisfies the requirement for the baseline data related to dissemination of the current medication list.

Communicating with patients and carers

Education of patients and carers is facilitated by the Consumer Medicines Information (CMI) for lower risk patients, and directly by the ward clinical pharmacists for higher risk patients. The clinical pharmacist network within NBH is extensive.

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	N/A	N/A
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	N/A	N/A
4.4.1	SM	SM
4.4.2	N/A	N/A
4.5.1	SM	SM
4.5.2	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
4.11.1	SM	SM
4.11.2	N/A	N/A

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 : Northern Beaches Hospital
Orgcode : 126924

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Patient identification and procedure matching in NBH is supported by numerous HSP policies, readily available on HINT. Arm bands are compliant with national specifications.

Three identifiers are used for all ward and unit patients, and compliance audits are scheduled including in clinical handover, procedure matching in Theatres, and expressed breast milk auditing. Identification of neonates, including twin births is appropriate. Photographs and two identifiers will be organised in the inpatient mental health unit to further enhance patient identification.

Incidents are managed via the RiskMan system according to HSP policy.

Processes to transfer care

A number of HSP policies guide the processes for transferring patients both within the hospital and between hospitals. The ISBAR (Identify, Situation, Background, Assessment and Recommendation) communication tool is used to confirm patient identification. The eMR electronic discharge and transfers requires 4 identifiers.

Processes to match patients and their care

Team time-out is documented in the eMR in surgery and is based on the World Health Organisation (WHO) guidelines for safe surgery. Some other high-risk areas like the day medical unit (chemotherapy patients) have documented team time-out processes in place. There is an opportunity to extend time-out processes for ward and unit-based procedures. Team time-out audit tools are in place and scheduled.

Organisation : Northern Beaches Hospital
Orgcode : 126924

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	N/A	N/A
5.2.1	SM	SM
5.2.2	N/A	N/A
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	N/A	N/A

Organisation : Northern Beaches Hospital
Orgcode : 126924

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

A comprehensive range of policies and procedures are in place which identify handover at every point of care. There are systematic inter-departmental handover processes, checklists and discharge criteria. The ISBAR tool has been adopted as the standard format for clinical handover. Clinical Handover education commences at orientation and is provided face-to-face, via eLearning and videos.

Specific departments such as Mental Health are governed by The NSW Transfer of Care Policy for Mental Health Inpatient Services as well as HSP and NBH policies and procedures.

Clinical handover processes

Key Clinical Handover Principles guide handover and include participants' involvement as well as place and time.

A printed patient information sheet is available to staff members involved in handover. At ward level, handovers include an initial meeting of the ward nursing staff followed by a handover by staff members caring for specific patients. Bedside handover is conducted, and each patient care plan is discussed.

In relation to the emergency department and critical care units, handover is led by the VMOs/Consultants. Junior doctors, nursing staff and allied health are also involved at dedicated times during the day and night. The specialist mental health team are acknowledged as a critical service who provide leadership and triage education for staff in the identification and management of patients displaying mental health issues.

The Interventional Suite (theatres) conduct time out and both the theatres and recovery room have robust inter-department admission and discharge criteria to be followed. Auditing for compliance is underway. Radiology also has handover procedures appropriate for their service.

Communication books, staff "huddles" and journey/patient boards are also used, providing clinical staff with communication strategies for an effective handover.

Progress note entries are documented in the eMR allowing any clinician at any time to view the progress of the patient's care. Specific medical records such as the NIMC remain hard copy. There are good relationships with Radiology and Pathology to ensure results are available in a timely manner.

Pharmacy Services are on-site to manage medications for patients and to provide clinical services to the doctors and staff.

Audit and incident reporting systems are in place and results monitored by the PCRC, the MAC and at corporate and cluster level.

GPs as well as external community services and Aged Care facilities are also recognised and included in discharge planning as the need arises.

Patient and carer involvement in clinical handover

The Electronic Patient Satisfaction Survey System Qualtrics now includes a question “Have you been involved in handover”; this information is captured and fed back to the departments in real time.

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	N/A	N/A
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	N/A	N/A
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	N/A	N/A

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	N/A	N/A

Organisation : Northern Beaches Hospital
Orgcode : 126924

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

The systems for blood and blood product prescribing and clinical use across NBH is safe and appropriate, and the responsibility for blood and blood product governance is held by the NBH Pathology and Transfusion Committee. The HSP Transfusion Cluster also supports Blood and Blood Product safety.

Incidents are recorded and investigated in RiskMan as well as via the BloodNet system in the Laboratory, and escalated within NBH, HSP and to national Haemovigilance programs as appropriate.

The comprehensive HSP transfusion audit is scheduled.

Documenting patient information

All requests for blood and blood products are compliant with the relevant standards. The best possible transfusion history is facilitated by the Transfusion Record Form on the eMR. The need for informed consent for transfusion episodes (including Anti-D) is well understood. There is a zero-tolerance approach by the Laboratory in regard to documentation for specimen collection.

Managing blood and blood product safety

Bloodsafe eLearning is mandatory for all staff involved in blood and blood product use in NBH, as required by HSP policy. Completion records have been transcribed into the HSP ELMO system.

Timely cross-match of packed cells when the patient is deemed by clinicians as ready for transfusion is assisted by a functional laboratory system. This has reduced the inventory required in the blood bank.

There was evidence of excellent communication links and supply chain coordination for the Massive Blood Transfusion incident required in the first week of NBH operation, which is a notable early achievement in blood and blood product safety.

Utilisation and wastage across NBH is well monitored and will be reported to the peak committee.

There are comprehensive audit tools available and audits are scheduled.

Communicating with patients and carers

A major focus of the patient blood management program is to ensure patients are aware of the options, as well as risks and benefits of blood product transfusion. The focus on optimising haemoglobin levels in the Pre-admission Clinic will reduce blood transfusion requirements.

Information is provided to all patients as part of the Patient Information Guide. For those patients requiring blood or blood products, brochures are available in multiple languages to assist the consenting process. The Interpreter service is also available.

Consent audits will be undertaken according to the prescribed schedule.

Organisation : Northern Beaches Hospital
Orgcode : 126924

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	N/A	N/A
7.2.1	SM	SM
7.2.2	N/A	N/A
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	N/A	N/A

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	N/A	N/A
7.6.1	SM	SM
7.6.2	N/A	N/A
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	N/A	N/A
7.8.1	SM	SM
7.8.2	N/A	N/A

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

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

It is evident that NBH has appropriate systems in place for the prevention and management of pressure injuries and this standard is supported by the Policy `Pressure Injury – prevention, identification & management'. The policy was developed by the Healthscope Pressure Injury Prevention Working Party and it incorporates the national best practice guidelines to ensure that evidence-based policies, procedures and assessment tools are in place for the prevention and management of pressure injuries.

NBH has a comprehensive audit system and calendar schedule; with the Minimising Patient Harm audit assessing compliance against the pressure injury policy, the risk assessment process and use of the tool. Audit results are then reported on a monthly basis to the PCRC and Executive Committee for review and action. NBH uses RiskMan for their risk management system, with all pressure injuries entered, with stage 3 & 4 pressure injuries reported directly to the Healthscope National Clinical Risk Manager.

NBH has processes in place for the provision of appropriate equipment and devices to prevent pressure injury and this is captured in the electronic equipment and devices register. The equipment at NBH is state of the art and in sufficient numbers for optimal patient care. The assessment team was very impressed with the central equipment store and with the equipment that had been trialled and evaluated by staff prior to purchase. The equipment was also easily located via an electronic tracking system to minimise delays in finding the right equipment at the right time.

Preventing pressure injuries

The Healthscope risk assessment tool for pressure injuries is based on the best practice guidelines and is effectively integrated into the eMR (with back up paper copies available); whereby the eMR tool will also collate the scoring and offer staff `drop down' information box options depending on the severity rating of the assessment. This is a great technological innovation that will no doubt assist staff and benefit patients. The screening tool also incorporates an individual patient preventative management plan for all staff to follow. The Patient Information Guide (approved by consumers) has preventative information for patients and also their carers at their bedside.

Regular skin assessments, as per the comprehensive skin assessment form, begins at the admission process with the completion of the patient health history form and then continually throughout the patients stay until discharge. The skin assessments are communicated through clinical handover and also then included in the discharge summary. NBH has a comprehensive audit system, with skin assessments and the presence of wounds being made mandatory information to be included in the electronic discharge summary. The eMR assists with audits which are reported to the PCRC and then fed back to staff at Department level. Also, ACHS clinical indicator data for pressure injuries is to be reported monthly and results uploaded to the MyHealthscope Website.

Managing pressure injuries

The NBH policy for 'Pressure Injury - prevention, identification & management' is based on the national best practice guidelines and directs staff to commence a wound management plan for all patients who either present or develop a pressure injury. Additional pressure injury resources and product guides for staff are available on the shared drive via HINT and the Minimising Patient Harm audit and the patient clinical record audits will assess compliance with the completion of the pressure injury management plans.

Communicating with patients and carers

It is evident to the assessment team that NBH involves patients and carers in the prevention and management of pressure injuries. The NBH best practice policy and the staff education & training provides a clear process which prompts staff to engage patients in this process. The patient and their carers/family have access to the printed information in the Patient Information Guide, regarding the prevention of pressure injuries whilst in hospital. The risk assessment tool has prompts for staff to provide further information to patients when they reach a higher risk level. The MyHealthscope Website includes pressure injury benchmarked data that is available to the community and consumers.

NBH policy directs all staff to develop the nursing care plan in partnership with the patient and/or carer which documents their involvement or reasons why they cannot be involved at this stage. Staff utilise the care plans during handover at the bedside to ensure the patient and/or carers are involved and they are also encouraged to read and also use the communication `care board'.

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	N/A	N/A
8.3.1	N/A	N/A
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	N/A	N/A
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	N/A	N/A
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	N/A	N/A

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	N/A	N/A

Organisation : Northern Beaches Hospital
Orgcode : 126924

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

Organisation : Northern Beaches Hospital
Orgcode : 126924

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

Surveyor Summary

Establishing recognition and response systems

The hospital is to be commended on their management of systems for the deteriorating patient.

Evidence based policies and procedures are in place. Significant work and education has been conducted for clinical departments such as, the Emergency Department, CCUs, ICU, HDUs, general wards, day surgery and the Interventional suite to ensure robust systems are in place to recognise the deteriorating patient. Evidence based tools are used which allows evaluation and auditing to be measured and compared in a systematic way.

The Critical Care Committee has been established and is already reporting the number of MET (Medical Emergency Team) calls, code blue events and rapid response outcomes.

The assessors witnessed a code blue whilst on a visit to a ward. The debriefing session with the staff, led by the VMO who attended, had only praise for everyone who in such a short time were able to respond, access the emergency trolley and knew where every piece of resuscitation equipment was located.

Recognising clinical deterioration and escalating care

Track and trigger adult and paediatric observation charts and the ISBAR communication tool are used to report clinical deterioration. Clinical deterioration events are registered on RiskMan and escalated to senior management if the need arises. Staff feedback is positive and they stated that they felt confident when making a call.

Emergency Response Data collection tool is in place to capture events as they occur.

Mortality and Morbidity reviews are already underway and form part of the Patient Care Review Committee (PCRC) with the results to be presented at the MAC and any recommendations are actioned accordingly.

Responding to clinical deterioration

Policies and procedures are well established and support the management of the deteriorating patient.

There has been a significant focus on education and training for all staff commencing at orientation and is ongoing.

BLS, PLS, PALS and ALS education has been conducted for all clinical staff resulting in a high compliance rate hospital wide.

Emergency trolleys are well equipped and checked daily.

MET call flowcharts are in place in all clinical units. MET calls and up transfers are monitored and reviewed when the need arises. Clinical staff are aware of their responsibilities in regard to assessment and code blue.

Good relationships are established with North Shore Hospital and the Ambulance Service if needed.

Communicating with patients and carers

There is information readily available to patients and carers to understand how they are able to escalate clinical concerns. The bedside directory includes instruction for the use of the emergency call bell in the event of serious concerns. Video orientation is provided, patient care boards can be used to write down any questions and bedside handover is another patient centred care initiative for patients to ask questions regarding their care.

Alerts and medical treatment orders are captured on the eMR and reviewed by the Senior Medical Practitioner as indicated.

Policies are in place regarding Advanced Life Directives and treatment options. The NSW Health “Advanced Care and Planning” brochure is available in the clinical departments.

RiskMan is used for collecting incidents in relation to emergency call bell responses. Reports are provided to the Critical Care Committee and the PCRC.

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	N/A	N/A

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	N/A	N/A
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	N/A	N/A

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:

Over 90% of all clinical staff have been trained in Basic Life Support. This includes staff transferred from Manly/Mona Vale as well as all newly recruited staff.

The Education Centre has reviewed staff profiles to ensure appropriately skilled and trained staff are assigned and rostered to the relevant clinical departments.

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

NBH has clear and effective governance systems in place for the prevention and management of falls and this is underpinned by the Healthscope Policy `Falls prevention & management'. The policy was developed by the Healthscope Falls Prevention Cluster and it incorporates the national best practice guidelines to ensure that evidence-based policies, procedures and assessment tools are in place for the prevention and management of falls.

NBH has a comprehensive audit system and calendar schedule; with the Minimising Patient Harm audit assessing compliance against the falls prevention & management policy, the risk assessment process and use of the management guidelines. Audit results are then reported on a monthly basis to the PCRC and Executive Committee for review and action, with the results disseminated to each Department. All falls are entered on RiskMan and managed by the NUM in the first instance (including corrective actions), and then reviewed by the Quality Manager.

The assessment team was very impressed with the quarterly “Shared Learnings” report from Healthscope which lists all the national sentinel events and near misses. The learnings are a standing agenda item at NBH committee meetings and require mandatory sign off by the Executive. The shared learnings document also includes valuable information on “falls”, included any recommended changes to practice or equipment that need to be implemented by NBH.

NBH has processes in place for the provision of appropriate equipment and devices to prevent falls and this is captured in the electronic equipment and devices register. The equipment at NBH is state of the art and in sufficient numbers for optimal patient care; including bed sides where each side has the option of lifting fully or only half; and also mobility aids, grip socks and alarms. The equipment is also easily located via an electronic tracking system to minimise delays in finding the right equipment at the right time.

Screening and assessing risks of falls and harm from falling

The Healthscope risk assessment and management tool for falls is based on the best practice guidelines (ACSQHC guidelines) and is effectively integrated into the eMR (with backup paper copies available); whereby the eMR tool will also collate the scoring and offer staff `drop down' information box options depending on the severity rating of the assessment. This is a great technological innovation that will no doubt assist staff and benefit patients. The screening tool also incorporates an individual patient preventative management plan for all staff to follow. The Patient Information Guide (approved by consumers) has falls preventative information for patients and also their carers at their bedside.

The falls assessment process for the identification of patients who are a falls risk commence at either pre-admission, with the self-reported falls assessment or on admission (i.e. within 24 hours of admission). The NBH policy also directs the need for continued assessment following surgery, change in condition and transfers to other wards.

NBH has a comprehensive audit system using RiskMan as the risk management platform, with risk of fall assessments on admission and a risk score allocated, being made mandatory information and also included in the electronic discharge summary. The eMR assists with audits which are reported to the PCRC and then fed back to staff at Department level.

Preventing falls and harm from falling

NBH utilises a Healthscope Falls Prevention and management policy to direct practice and the Falls Risk assessment & management tool (FRAT), based on the national best practice guidelines and fully integrated into the eMR to assist clinicians. The tool allows clinicians to include preventative strategies for all risk of fall assessments and these are communicated through rounding and the clinical handover process.

Those patients assessed at a risk of fall, for example confused patients, will have preventative strategies identified and implemented by the staff that could include seeing the patient nursed close to the nurses station, having their bed lowered, stand-up alarm activated and grip socks in place.

Communicating with patients and carers

The NBH Falls Prevention and management policy directs all staff to develop the nursing care plan in partnership with the patient and/or carer which documents their involvement or reasons why they cannot be involved at this stage. Patients are provided with information on Falls Prevention on admission and Staff utilise the care plans during handover at the bedside to ensure the patient and/or carers are involved in discussing the risk of falls and they are also encouraged to read the Patient Information Guide (falls section) and also use the communication 'care board'. This education is ongoing and monitored daily with the notation of discussion in the patient's care plan daily.

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	N/A	N/A
10.3.1	N/A	N/A
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	N/A	N/A
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	N/A	N/A

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	N/A	N/A
10.8.1	SM	SM

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Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

STANDARD 11
SERVICE DELIVERY

Surveyor Summary

Information about services

Informing and engaging with consumers and the community began with the planning of NBH in April 2015. This included the undertaking of community consultation groups and community stakeholder forums. . Since the opening of the hospital there have been tours of the facility and also regular patient group meetings for those patients undergoing chemotherapy and renal dialysis by way of example. There are overarching communication strategy policies that guide the communication principles at NBH including the NBH Stakeholder Engagement & Communications Strategy; the Community Engagement subplan; and the Consumer and Carer subplan.

The NBH Website has comprehensive community engagement, and the patients are also linked to the NBH APP from the admission process which allows their families and carers to keep up to date on their progress through Theatres, Recovery and when they return to the Ward and Day Surgery.

NBH has engaged and communicated with external service providers who may refer patients to the hospital and they have also been engaged through GP information nights, events for Practice Managers and hospital tours.

Access and admission to services

The assessment team visited and met with staff and patients in clinical services and were appraised of a range of different access and admission routes in place depending upon the type of service and the needs of the patients. The team noted that admission pathways could be through the Emergency Department, Delivery Suite, and Outpatients or via Admissions for elective surgery. There are Healthscope policies utilised by NBH on triage and exclusion criteria with clear directions for a number of different clinical disciplines such as Paediatrics, Mental Health ICU and HDUs. The team noted the planned design which facilitates the separation of paediatrics and adults in the Emergency Department; the designated access to the ED safe room has been well planned and provides a safe environment in which vulnerable adults and children can receive care.

NBH has twice-daily patient flow update meetings and the Waiting List Coordinator manages & prioritises public patients as per the NSW Health Policy on “Waiting time and elective surgery”. The Executive receive a weekly report on any access block in ED and the length of waiting lists and inter-hospital transfers are monitored and reviewed for appropriateness.

Consumer / Patient Consent

The NBH uses the overarching Healthscope consent policy with local procedures to support this. Systems for obtaining and managing consent are governed by a comprehensive list of Healthscope Policies that include consent to medical treatment; blood transfusions; ECT; and advanced care directives. The policies clarify the different types of consent and also comply with NSW Health legislation.

Interpreter services are available when consent and understanding is limited by language abilities and where translated documents are not available. Informed consent is audited using a variety of schedules and platforms including the annual documentation audit, the annual team time out audit and the annual mental health time out ECT audit.

Appropriate and effective care

It is clear that the hospital provides care in accordance with the NBH Clinical Services Delivery Plan and evaluates the effectiveness and appropriateness of care using the Clinical Governance and Quality & Safety System. The accreditation and credentialing of medical specialists adheres to the Healthscope By-laws and this process at NBH began over 12 months ago; specialist appointment is based on the service requirements of NBH. The medical specialist position descriptions include their approved scope of practice.

The NBH Medical Advisory Committee (MAC) has been established for over 12 months now and has concentrated on the medical appointments and credentialing process. The MAC is now working closely with each clinical department to establish effective peer review meetings, morbidity & mortality meetings, critical incident reviews, unplanned re-admissions and review of compliance audits.

Diverse needs and diverse backgrounds

The assessment team noted that the NBH staff have access to multicultural resources reviewed by consumers and are supported to deliver culturally appropriate care. The access and use of interpreter services ensures that clinical assessments are conducted with the specific clients' needs being at the forefront of care.

The NBH policy on Interpreter Services ensures clear direction for the staff needing to access these services for their patients and/or carers and it was also noted that the consumer approved 'Patient Information Guide" has been translated into the main languages for its catchment population. NBH also considers the patients cultural and spiritual needs; and they have specific policies on gender identity; diversity & inclusion; CALD groups; End of Life; and pastoral care. Healthscope are progressing engagement with the ATSI working group and working towards a reconciliation action plan, which will assist NBH's work with the local Aboriginal Elders.

Population health

The assessors also noted the strong focus on population health being demonstrated through the implementation of a number of new initiatives that include the NBH policy "Towards Normal Birth" to reduce rates of Caesarian Section; the acute cardiac rehabilitation program and the "Safe Start" program. The assessment team will be interested to see the progress and effect of these programs at the next assessment, as they readily come into practice.

The NBH plans to collect a significant number of health surveillance data for both state and national agencies including data on ATSI women who have antenatal care prior to 14 weeks; or have an unplanned re-admission with 28 days; or an unplanned readmission to ED within 48 hours as well as the percentage of Aboriginal people in the Healthscope workforce.

NBH also has effective practices and policies (Policy - Notification of Infectious Diseases) in place to meet its legislative requirements for reporting on infectious diseases such as tuberculosis (TB).

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Information about services

Ratings

Action	Organisation	Surveyor
11.1.1	SM	SM
11.1.2	N/A	N/A
11.2.1	SM	SM
11.2.2	SM	SM

Access and admission to services

Ratings

Action	Organisation	Surveyor
11.3.1	SM	SM

Consumer / Patient Consent

Ratings

Action	Organisation	Surveyor
11.4.1	SM	SM
11.4.2	N/A	N/A

Appropriate and effective care

Ratings

Action	Organisation	Surveyor
11.5.1	SM	SM
11.5.2	SM	SM

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Diverse needs and diverse backgrounds

Ratings

Action	Organisation	Surveyor
11.6.1	SM	SM
11.7.1	SM	SM
11.7.2	SM	SM

Population health

Ratings

Action	Organisation	Surveyor
11.8.1	SM	SM
11.9.1	SM	SM
11.9.2	SM	SM
11.10.1	N/A	N/A

STANDARD 12
PROVISION OF CARE

Surveyor Summary

Assessment and care planning

NBH utilises the Healthscope assessment policies and tools to assist staff with the assessment process, which is conducted in partnership with carers and patients to ensure that the admission includes their physical, social, cultural and spiritual needs. The Healthscope Clinical Clusters review and approve the assessment tools to ensure they are based on best evidenced practice. Information received at pre-admission or on admission is entered directly into the eMR and it includes their language; religion; cultural background; any advanced care directives, organ donor status, medications, menu options and discharge planning. NBH has a multi-faith room available for patients and carers and there are pastoral care options offered during the assessment.

NBH resource guides for staff to access for ATSI patients are available on HINT, and all Healthscope Hospital points of contact enable self-identification by ATSI patients. Staff are also supported to deliver culturally appropriate care to ensure that clinical assessments and risk assessments are conducted with the specific patient's needs being at the forefront of care. Healthscope is in the process of finalising the national Reconciliation Action Plan (RAP) and this will then be localised for NBH.

The nursing care plan is commenced on admission in consultation with the patient and/or carer and includes a patient assessment using one of the many NBH risk assessment tools. All the tools have been developed as per the best practice guideline for each clinical discipline or each individual risk for example, falls and pressure injury. The NBH audit schedule also targets patient assessments and includes one for documentation; minimising patient harm; and medication safety. The audit results are reported to and actioned by the PCRC.

The NBH referral processes are guided by a number of key policies specific to specialty areas, which have been developed with consumer input and designed specific to the needs of clients and consumers in the clinical specialties. There were a number of examples of care plans in units that have been developed with direct input from the client and or family. Discharge summaries are emailed to the patient's GP and they are also given a printed copy on discharge. Printed copies are also used for inter-hospital transfers.

Care planning with the patient begins at the first assessment or admission and NBH has policies to direct staff to complete an individual care plan for each patient, which in turn has alerts uploaded into the eMR. NBH is using and electronic form of `between the flags' whereby mandatory clinical escalation protocols commence when observations exceed the normal parameters. The patient journey boards were to be utilised to assist with the care planning process for patients but their implementation across NBH has been implemented in an ad hoc manner and this will need to be addressed in coming months.

The discharge process commences at pre-admission and admission and this is well documented in Healthscope policies discharge of a patient - against medical advice; and inter-hospital transfers. Discharge planning is incorporated into all care plans, the patient journey board (in most departments) and also the patient care board. The rates of completed discharge summaries are identified by regular audits across Healthscope and these statistics are uploaded on the MyHealthscope Website.

Management of nutrition

It is evident that NBH has appropriate policies and systems in place to ensure that the nutritional needs of patients are met. The management of nutrition at NBH is governed by a comprehensive policy called Diet and Nutrition – adult inpatients and the Nutrition and Dietetics Assessment form; which is based on national best practice guidelines. Policies, procedures and assessment tools are in place for the management of nutritional needs of patients.

Patients are weighed on admission and a comprehensive diet screening history is taken. Dietary requirements and meal assistance needs are documented in the patient care plan and communicated to the treating team and food services. All patients admitted for more than 24 hours are screened for risk of malnutrition using a validated tool and this is then continued on a weekly basis or following a change in the patient's condition. Any patients identified at risk of malnutrition are referred to the Dietician who will develop a nutrition and hydration plan. This plan includes information being recorded in the Nutrition and Dietetics Assessment form; Enteral Feed chart; TPN and the Fluid Intake record.

NBH has flagged with the assessors that they are considering a trial of `protected meal times', which would greatly enhance the patient experience.

The NBH nutrition management strategy is governed by their Food Safety Plan and HCCAP guidelines. The Director of Allied Health oversees the NBH Dieticians and liaises closely with the Catering Services Manager. The NBH orientation program for all staff included education on catering and dietetic services. Chef Max is the electronic diet menu software which incorporates a list of diet codes for patients' specific dietary requirements such as diabetic, gluten free and modified diets. The code when ticked generates a standard recipe for the chefs and cooks to follow. The recipes have been reviewed by the Diet Committee for calorie, portion control and nutrition value.

Ongoing care and discharge / transfer

NBH has many multidisciplinary processes and policies to support and streamline patient discharge. NBH has detailed the discharge process for all staff in the `Discharge of a Patient' policy and the `Discharge Planning and Procedure' policy. The assessment of discharge commences on pre-admission and admission and is ongoing as part of the multidisciplinary journey board discussions incorporating discharge dates. The patient's estimated discharge date is included on the ward journey boards and patient care boards. The patient bedside televisions also have an information video which includes discharge planning.

Referral pathways have been developed with external providers to facilitate the discharge and ongoing care of NBH patients. Discharge summaries are included in the eMR and are emailed to the patient's referring doctor (GP) when the patient is discharged. All pathology and radiology results are available within the eMR to ensure that all information is conveyed to referrers. Healthscope has developed and utilises key performance indicators to evaluate their re-admission rates and NBH will be included in this data to see how they perform against peer hospital benchmarks.

End-of-life care

It is evident that Healthscope and now NBH, has appropriate systems in place for supporting and managing end-of-life care. There are Healthscope and NBH policies that cover advanced care directives; spiritual care; organ donations; end-of-life decision making; and death of a patient. Evidence based policies, procedures, work instructions and guidelines to support end of life care are evident and/or under review. It was noted that education was not included at orientation for migrating staff but will now be included at NBH moving forward.

The Mortuary has policies and procedures in place to manage the deceased person with respect and dignity. A viewing room is available and discreetly housed within the Mortuary.

As part of end-of-life care, NBH supports organ and tissue donation for the purposes of transplantation. A comprehensive policy called Organ and Tissue Donation, is in place to ensure that organ and tissue donation is conducted in accordance with all legal requirements and the best available evidence.

Pastoral Care services have a particular focus on the care of dying patients and support of the family during this time and EAP is provided to support staff with confidential counselling support. A multi-faith room is available on level 5 of NBH.

Assessment and care planning

Ratings

Action	Organisation	Surveyor
12.1.1	SM	SM
12.1.2	SM	SM
12.2.1	SM	SM
12.2.2	SM	SM
12.3.1	SM	SM
12.4.1	SM	SM

Management of nutrition

Ratings

Action	Organisation	Surveyor
12.5.1	SM	SM
12.5.2	N/A	N/A
12.6.1	SM	SM
12.6.2	SM	SM
12.6.3	SM	SM
12.7.1	SM	SM
12.7.2	SM	SM

Ongoing care and discharge / transfer

Ratings

Action	Organisation	Surveyor
12.8.1	SM	SM
12.8.2	SM	SM
12.8.3	SM	SM
12.9.1	SM	SM
12.10.1	SM	SM
12.10.2	SM	SM
12.10.3	SM	SM

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End-of-life care

Ratings

Action	Organisation	Surveyor
12.11.1	SM	SM
12.11.2	SM	SM
12.12.1	SM	SM
12.12.2	SM	SM

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STANDARD 13
WORKFORCE PLANNING AND MANAGEMENT

Surveyor Summary

Workforce planning

Workforce planning is managed by the NBH Human Resource Manager who is a member of the NBH executive. NBH has a workforce plan, policies and procedures and position descriptions for all staff. The Kronos Rostering system is used to ensure safe work hours. The rostering system is supported by policies and procedures and guidelines. A workforce contingency plan has been developed.

Recruitment processes

A NBH Workforce Plan is in place. To meet the needs of the projected scope of activity, a workforce plan was developed, which included the migration of the workforce from the Manly and Mona Vale Hospitals.

HSP has a robust organisation-wide recruitment, selection and appointment system that is being used at NBH. The system has been used in the selection and migration of staff from former State hospitals to the new NBH. An on-boarding survey is planned for 30 days post opening to evaluate the new NBH recruitment and selection processes.

A NBH workforce manager will ensure workforce policies and procedures, guidelines, supervision, position descriptions and staff education are carried out in accordance with HSP workforce governance expectation.

HSP had developed and implemented a range of project plans with the view to ensuring safe quality care from the outset of NBH becoming operational. The identification of an appropriate skill mix to meet the patient clinical care requirements was stated to have been an absolute priority during the developmental phase. Contingency plans have been developed to address staff shortages. All clinical workforce streams have a clear line of management and supervision.

A review of the credentialing system during the interim assessment found that it was being used effectively and is consistent with National standards and guidelines, HSP policies and procedures and professional standards. Comprehensive HSP by-laws guide credentialing and scope of practice management. A NBH MAC has been established to manage ongoing credentialing and scope of practice business. NBH is required to audit and report compliance with registration and credentialing to HSP each month.

Evidence was found during the interim assessment that even during the first week of operation the blended workforce had begun providing care and services effectively. Meetings held with the Medical Advisory Committee (MAC) Clinical leads and Unit Managers confirmed their involvement to ensure the right skill mix and qualified staff were rostered and available. This was verified when visiting the various departments that staff were working collaboratively.

Continuing employment and development

NBH has systems in place to manage personnel records securely. Personnel records are electronic. NBH is expected to comply with the HSP policy for mandatory training and ongoing education. The ELMO Database is used to capture and evaluate training compliance.

The HSP policy for Performance Review (PPR) and Development will be used at NBH. Clear guidelines are in place. A range of templates and toolkits are available to assist managers and supervisors with PPR processes. Clear HSP policies and procedures and guidelines are available to manage any complaint or concern about staff performance.

Employee support and workplace relations

Significant effort was undertaken to consult with unions during the process of migrating staff from the Manly and Mona Vale State hospitals to the new NBH. A Workplace Relation Team managed the negotiations and a contracted recruitment agency was used to assist with the very extensive recruitment processes undertaken to employ staff during the commissioning phase of NBH.

An Employee Assistance Scheme is in place for the NBH staff.

Workforce planning

Ratings

Action	Organisation	Surveyor
13.1.1	SM	SM
13.1.2	N/A	N/A
13.2.1	SM	SM
13.3.1	SM	SM

Recruitment processes

Ratings

Action	Organisation	Surveyor
13.4.1	SM	SM
13.5.1	SM	SM
13.5.2	SM	SM
13.6.1	SM	SM

Continuing employment and development

Ratings

Action	Organisation	Surveyor
13.7.1	SM	SM
13.7.2	SM	SM
13.8.1	SM	SM
13.8.2	SM	SM
13.8.3	N/A	N/A
13.9.1	SM	SM
13.9.2	SM	SM

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Employee support and workplace relations

Ratings

Action	Organisation	Surveyor
13.10.1	SM	SM
13.10.2	SM	SM
13.11.1	SM	SM
13.12.1	N/A	N/A
13.13.1	SM	SM

Organisation : Northern Beaches Hospital
Orgcode : 126924

STANDARD 14
INFORMATION MANAGEMENT

Surveyor Summary

Health records management

The HSP organisation-wide health records management system has been implemented at the NBH. Patient records are tracked using the WebPas system. HSP ensures each patient is allocated a unique patient identifier number. Auditing and monitoring processes are in place.

The HSP clinical coding and reporting system has been implemented. Reporting is expected to be undertaken in line with Health Information Services Procedures. Staff training and reporting processes are already operational.

Corporate records management

A NBH Information Management and Technology Plan is in place to ensure clinical and non-clinical data and information is accurate, complete and meets the needs of NBH.

Collection, use and storage of information

WebPas is the Patient Management System and captures both the individual patient record and other statistical data. The new NBH data systems were subjected to extensive testing prior to commencement of services.

The NBH information management system is complex one and has to function across the public and private patient care services, third party diagnostic services and external agencies. HSP provides enterprise-wide support for regular auditing and accreditation reviews with reports provided to HSP and NBH executive.

Information and communication technology

HSP has a robust ICT system that is continually monitored. An IM &T project plan was used to manage the implementation and use of the new NBH ICT system. HSP has an Information Security Strategy and a Disaster Recovery Plan as well as policies and procedures and guidelines to guide backup processes, data security and business continuity systems. Governance is provided by an Information Security Committee.

The HSP National Information Security Manager is responsible for the management and evaluation of the ICT system and data security. A comprehensive vulnerability management program is used to ensure any emerging threats will be proactively identified and addressed. A cyber expert is based at HSP head office and is responsible for maintaining cyber security. NBH has an ICT incident response plan in place. Security awareness education for staff is a component of the security strategy.

Health records management

Ratings

Action	Organisation	Surveyor
14.1.1	SM	SM
14.2.1	SM	SM
14.3.1	SM	SM
14.3.2	SM	SM
14.4.1	SM	SM

Corporate records management

Ratings

Action	Organisation	Surveyor
14.5.1	SM	SM

Collection, use and storage of information

Ratings

Action	Organisation	Surveyor
14.6.1	SM	SM
14.6.2	SM	SM
14.7.1	SM	SM
14.8.1	SM	SM

Information and communication technology

Ratings

Action	Organisation	Surveyor
14.9.1	SM	SM
14.9.2	SM	SM

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STANDARD 15
CORPORATE SYSTEMS AND SAFETY

Surveyor Summary

Strategic and operational planning

The new NBH is guided by the Healthscope Strategic Plan, Code of Conduct, policies and procedures and governance systems including: quality and safety, risks, workforce management, information, technology and emergencies. A new NBH Strategic Plan is currently being completed now that the hospital has been commissioned. Formal systems are outlined in the organisational and committee structures and reporting plan. A clinical governance system manages clinical practices, clinical staff education and competencies. NBH Quality Safety Plan and improvement processes are in place. Every committee has Terms of Reference by which they will be evaluated annually.

Systems and delegation practices

The governing body of Healthscope (HSP) is the HSP Board which has clear roles, responsibilities and delegations. NBH was found to have clearly defined organisation and committee structures. A formal system for delegations has been established. Position Descriptions set out key performance criteria. Processes have been developed for monitoring compliance with delegations. HSP provides comprehensive, compliant financial management processes and policies and procedures for the NBH.

External Service Providers

The NBH external services providers will be managed as prescribed by HSP policies and systems. Each external service provided will have a formal contract and a Code of Conduct against which their service will be evaluated and their compliance monitored. Each agency is expected to provide monthly reports to NBH as well as report WH&S and/or other incidents.

Research Governance

Research will, in the future, be undertaken at NBH as per the HSP policies.

Safety management systems

NBH safety management systems are being implemented based on HSP policies and procedures that reference relevant legislation, Australian Standards (AS), industry guidelines and codes of practice. A HSP policy requires that all staff complete mandatory training for work health and safety (WHS). The NBH WHS system includes: a WHS committee with TOR, an audit schedule, risk assessments, safe operating procedures, staff education, injury management and incident reporting. WHS manager and fire wardens have received orientation and the appropriate training. Chemwatch will be used for online chemical management and information at NBH. NBH has a Radiation Safety Plan. Medical imaging services are provided by an external third-party service that provides regular reports to the NBH executive.

Buildings, plant and equipment

A procurement, management, risk reduction and maintenance system is in place. The NBH had to comply with all building, plant, medical equipment and other equipment prior to being permitted to formally commission the service and commence accepting patients.

Contracts, supply and distribution of consumables are managed by the national procurement team. All consumables in the national catalogue are TGA approved. Trials of new equipment are managed in consultation with the HSP procurement team. The procurement team also seeks clinical input through the clinical cluster.

At the time of the interim survey, the procurement team was on-site and actively engaged with numerous suppliers regarding consumables and supplies on back order and also increasing imprest levels of stock in general in the clinical units. When visiting the wards, there was a hive of activity by support staff to help stock and restock consumables in the new clean utility areas as supplies were arriving.

A QFM maintenance program is used to manage maintenance. Maintenance is being managed by an external contracted service. The QFM system provides compliance reports and maintenance plans each month.

The RiskMan system is used for the reporting and management of risks, incidents and hazards. Each department manager has a WHS Action Plan.

NBH uses their Building Maintenance System to monitor faults and the management of buildings and equipment. The WHS manager undertakes monthly audits. NBH signage complies with Building Codes of Australia.

Emergency and disaster management

NBH has plans in place for Emergency Management, Business Continuity, Pandemic Management and Fire Safety. It also has Chemical, Biological and Radiation Plans. A final Fire Safety Certificate and Occupancy Certificate were issued to NBH by an authorised certifier in May 2018.

Prior to the commissioning of NBH, a series of table top and multi-agency mock drills were undertaken. A drill for the management of a helipad emergency was also done. NBH has emergency events codes and fire emergency checklist in place. All managers have received emergency coordinator training provided by an external fire consultant. Staff have been provided emergency procedures education.

Physical and personal security

NBH has undertaken a Security Risk Assessment, developed a Security Plan and Policies and procedures for the management of security risks. Risks in relation to security are risk rated and prioritised for action. HSP has workplace aggression and violence management policies and procedures in place. All incidents related to physical and personal safety and security are expected to be entered into RiskMan.

Waste and environmental management

HSP has PP for the management of waste. An external company, Veolia, is used to manage NBH waste. Waste management effectiveness will be evaluated in accordance with the waste management policy. Managing resources sustainability is already a priority at NBH. During the design and construction of NBH the best possible standards for efficiency and sustainability were included and as a consequence it has been awarded a 4-star certificate from the Green Building Council of Australia. A water conservation system has been installed in the Sterile Services Department. Gardens use recycled water and are planted with low water use plants.

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Strategic and operational planning

Ratings

Action	Organisation	Surveyor
15.1.1	SM	SM
15.1.2	SM	SM
15.1.3	SM	SM
15.2.1	N/A	N/A
15.2.2	N/A	N/A

Systems and delegation practices

Ratings

Action	Organisation	Surveyor
15.3.1	SM	SM
15.4.1	SM	SM
15.5.1	N/A	N/A
15.6.1	SM	SM
15.7.1	SM	SM
15.8.1	SM	SM

External Service Providers

Ratings

Action	Organisation	Surveyor
15.9.1	SM	SM
15.9.2	N/A	N/A

Research Governance

Ratings

Action	Organisation	Surveyor
15.10.1	SM	SM
15.10.2	SM	SM
15.11.1	SM	SM
15.11.2	SM	SM

Safety management systems

Ratings

Action	Organisation	Surveyor
15.12.1	SM	SM
15.13.1	SM	SM
15.13.2	SM	SM
15.13.3	SM	SM
15.14.1	SM	SM

Buildings, plant and equipment

Ratings

Action	Organisation	Surveyor
15.15.1	SM	SM
15.15.2	SM	SM
15.16.1	SM	SM
15.16.2	SM	SM
15.17.1	SM	SM

Emergency and disaster management

Ratings

Action	Organisation	Surveyor
15.18.1	SM	SM
15.19.1	SM	SM
15.20.1	SM	SM
15.20.2	SM	SM

Physical and personal security

Ratings

Action	Organisation	Surveyor
15.21.1	SM	SM
15.21.2	SM	SM
15.22.1	SM	SM

15.22.2	SM	SM
15.23.1	SM	SM

Waste and environmental management

Ratings

Action	Organisation	Surveyor
15.24.1	SM	SM
15.25.1	SM	SM
15.26.1	SM	SM

Organisation : Northern Beaches Hospital
Orgcode : 126924

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	SM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	N/A	N/A
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	N/A	N/A
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	N/A	N/A
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	N/A	N/A

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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	N/A	N/A
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	N/A	N/A

Consumer partnership in designing care

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

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	N/A	N/A
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	N/A	N/A
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	N/A	N/A

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	SM	SM

	• antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	N/A	N/A
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	N/A	N/A
3.4.2	Compliance with changes in practice are monitored	N/A	N/A
3.4.3	The effectiveness of changes to practice are evaluated	N/A	N/A

Infection prevention and control strategies

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

3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	SM	SM

• cleaning resources and services
• risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved
• waste management within the clinical environment
• laundry and linen transportation, cleaning and storage
• appropriate use of personal protective equipment

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	N/A	N/A
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
4.5.1	The performance of the medication management system is regularly assessed	SM	SM
4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

Patient and carer involvement in clinical handover

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

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	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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	N/A	N/A

7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

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

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	N/A	N/A
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	N/A	N/A
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

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

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	N/A	N/A

Communicating with patients and carers

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

8.10.1	Pressure injury management plans are developed in partnership with patients and carers	SM	SM

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

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	N/A	N/A
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM

9.4.3	Action is taken to maximise the appropriate use of escalation processes	N/A	N/A

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 regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	N/A	N/A
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	N/A	N/A
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	N/A	N/A
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	N/A	N/A

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	N/A	N/A
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

Service Delivery

Information about services

Action	Description	Organisation's self-rating	Surveyor Rating
11.1.1	There is evidence of evaluation and improvement of the quality of information provided to consumers / patients and the community about: • services provided by the organisation • access to support services, including advocacy.	SM	SM
11.1.2	The organisation's processes for disseminating information on healthcare services are evaluated, and improved as required.	N/A	N/A
11.2.1	Healthcare providers within the organisation have information on relevant external services.	SM	SM
11.2.2	Relevant external service providers are provided with information on the health service and are informed of referral and entry processes.	SM	SM

Access and admission to services

Action	Description	Organisation's self-rating	Surveyor Rating
11.3.1	The organisation evaluates and improves its system for admission / entry and prioritisation of care, which includes: • documented processes for prioritisation • clear inclusion and/or exclusion criteria • management of waiting lists • minimisation of duplication • utilisation of information in referral documents from other service providers received on admission of the consumer / patient • management of access block.	SM	SM

Consumer / Patient Consent

Action	Description	Organisation's self-rating	Surveyor Rating
11.4.1	The organisation has implemented policies and procedures that address: • how consent is obtained • situations where implied consent is acceptable • situations where consent is unable to be given • when consent is not required • the limits of consent.	SM	SM
11.4.2	The consent system is evaluated, and improved as required.	N/A	N/A

Appropriate and effective care

Action	Description	Organisation's self-rating	Surveyor Rating
11.5.1	The organisation ensures appropriate and effective care through: • processes used to assess the appropriateness of care • an evaluation of the appropriateness of services provided • the involvement of clinicians, managers and consumers / patients in	SM	SM

	the evaluation of care and services.		
11.5.2	Policy / guidelines are implemented that address the appropriateness of the setting in which care is provided including when consumers / patients are accommodated outside the specialty ward area.	SM	SM

Diverse needs and diverse backgrounds

Action	Description	Organisation's self-rating	Surveyor Rating
11.6.1	The organisation obtains demographic data to: • identify the diverse needs and diverse backgrounds of consumers / patients and carers • monitor and improve access to appropriate services • improve cultural competence, awareness and safety.	SM	SM
11.7.1	Policies and procedures that consider cultural and spiritual needs are implemented to ensure that care, services and food are provided in a manner that is appropriate to consumers / patients with diverse needs and from diverse backgrounds.	SM	SM
11.7.2	Mechanisms are implemented to improve the delivery of care to diverse populations through: • demonstrated partnerships with local and national organisations • providing staff with opportunities for training.	SM	SM

Population health

Action	Description	Organisation's self-rating	Surveyor Rating
11.8.1	Performance measures are developed, and quantitative and/or qualitative data collected, to evaluate the effectiveness / outcomes of health promotion programs and interventions implemented by the organisation.	SM	SM
11.9.1	The organisation identifies and responds to emerging health trends.	SM	SM
11.9.2	The organisation meets its legislative requirements for reporting on public health matters.	SM	SM
11.10.1	There is evidence of evaluation and improvement of strategies to promote better health and wellbeing, which include: • undertaking opportunistic health promotion / education strategies in partnership with consumers / patients, carers, staff and the community • providing education, training and resources for staff to support the development of evidence-based health promotion programs and interventions.	N/A	N/A

Provision of Care

Assessment and care planning

Action	Description	Organisation's self-rating	Surveyor Rating
12.1.1	Guidelines are available and accessible by staff to assess physical, spiritual, cultural, psychological and social, and health promotion needs.	SM	SM
12.1.2	Guidelines are available and accessible by staff on the specific health needs of self-identified Aboriginal and Torres Strait Islander	SM	SM

	consumers / patients.		
12.2.1	The assessment process is evaluated to ensure that it includes: • timely assessment with consumer / patient and, where appropriate, carer participation • regular assessment of the consumer / patient need for pain / symptom management • provision of information to the consumer / patient on their health status.	SM	SM
12.2.2	Referral systems to other relevant service providers are evaluated, and improved as required.	SM	SM
12.3.1	Care planning and delivery are evaluated to ensure that they are: • effective • comprehensive • multidisciplinary • informed by assessment • documented in the health record • carried out with consumer / patient consent and, where appropriate, carer participation.	SM	SM
12.4.1	Planning for discharge / transfer of care is evaluated to ensure that it: • commences at assessment • is coordinated • consistently occurs • is multidisciplinary where appropriate • meets consumer / patient and carer needs.	SM	SM

Management of nutrition

Action	Description	Organisation's self-rating	Surveyor Rating
12.5.1	Policy / guidelines for: • delivery of nutritional care • prevention of malnutrition • assessment of need for assistance with meals are consistent with jurisdictional guidelines, adapted to local needs and implemented across the organisation.	SM	SM
12.5.2	The organisation’s strategic and coordinated approach to delivering consumer / patient-centred nutritional care is evaluated, and improved as required.	N/A	N/A
12.6.1	Food, fluid and nutritional care form part of an intervention and clinical treatment plan.	SM	SM
12.6.2	Relevant healthcare providers use an approved nutrition risk screening tool to assess consumers / patients: • on admission • following a change of health status • weekly thereafter and referrals to nutrition-related services occur when needed.	SM	SM
12.6.3	The adequacy of consumer / patient nutrition is actively monitored and reported, and improvement is made to the nutritional care as required.	SM	SM
12.7.1	A multidisciplinary team oversees the organisation’s nutrition management strategy to ensure that provision of food and fluid to	SM	SM

	consumers / patients is consistent with best-practice nutritional care.		
12.7.2	Education programs for relevant staff about their roles and responsibilities for delivering best-practice nutritional care and preventing malnutrition are evaluated, and improved as required.	SM	SM

Ongoing care and discharge / transfer

Action	Description	Organisation's self-rating	Surveyor Rating
12.8.1	Discharge / transfer information is discussed with the consumer / patient and a written discharge summary and/or discharge instructions are provided.	SM	SM
12.8.2	Arrangements with other service providers and, where appropriate, the carer are made with consumer / patient consent and input, and confirmed prior to discharge / transfer of care.	SM	SM
12.8.3	Results of investigations follow the consumer / patient through the referral system.	SM	SM
12.9.1	Formalised follow up occurs for identified at-risk consumers / patients.	SM	SM
12.10.1	Formal processes for timely, multidisciplinary care coordination and/or case management for consumers / patients with ongoing care needs are evaluated, and improved as required.	SM	SM
12.10.2	Systems for screening and prioritising consumers / patients with ongoing care needs who regularly require readmission are evaluated, and improved as required.	SM	SM
12.10.3	Education is provided to consumers / patients requiring ongoing care and, where appropriate, to their carers.	SM	SM

End-of-life care

Action	Description	Organisation's self-rating	Surveyor Rating
12.11.1	Policy and procedures for the management of consumer / patient end-of-life care consistent with jurisdictional legislation, policy and common law are available and staff receive relevant education.	SM	SM
12.11.2	There is policy / guidelines for supporting staff, consumers / patients and carers involved in organ and tissue donation.	SM	SM
12.12.1	Access to and effectiveness of end-of-life care is evaluated, including through the use of clinical review committees.	SM	SM
12.12.2	A support system is used to assist staff, relatives, carers and consumers / patients affected by a death.	SM	SM

Workforce Planning and Management

Workforce planning

Action	Description	Organisation's self-rating	Surveyor Rating
13.1.1	Workforce management functions and responsibilities are clearly identified and documented.	SM	SM
13.1.2	The workforce policy, procedures, plan, goals and strategic direction are regularly reviewed, evaluated, and improved as required.	N/A	N/A

13.2.1	Contingency plans are developed to maintain safe, quality care if prescribed levels of skill mix of clinical and support staff are not available, and in order to manage workforce shortages.	SM	SM
13.3.1	The system for managing safe working hours and fatigue prevention is evaluated, and improved as required.	SM	SM

Recruitment processes

Action	Description	Organisation's self-rating	Surveyor Rating
13.4.1	The organisation-wide recruitment, selection and appointment systems are evaluated, and adapted to changing service needs where required.	SM	SM
13.5.1	Recruitment processes ensure adequate staff numbers and that the workforce has the necessary licences, registration, qualifications, skills and experience to perform its work.	SM	SM
13.5.2	The credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians, which is consistent with national standards and guidelines and with organisational policy, is evaluated, and improved as required.	SM	SM
13.6.1	The volunteer recruitment system supports an adequate number and mix of volunteers to complement the work undertaken by paid staff.	SM	SM

Continuing employment and development

Action	Description	Organisation's self-rating	Surveyor Rating
13.7.1	Accurate and complete personnel records, including training records, are maintained and kept confidential.	SM	SM
13.7.2	There is a system to document training for staff and volunteers which is identified as necessary by the organisation.	SM	SM
13.8.1	The performance assessment and development system includes: • review of position descriptions • review of competencies • monitoring of compliance with published codes of professional practice • assessment of learning and development needs • provision of adequate resources for learning and development • management of identified performance needs.	SM	SM
13.8.2	Ongoing monitoring and review of clinicians' performance is linked to the credentialling system.	SM	SM
13.8.3	The performance assessment and development system is evaluated through appropriate stakeholder consultation, and improved as required.	N/A	N/A
13.9.1	Processes are in place for managing a complaint or concern about a clinician, and there is evidence that they have been used.	SM	SM
13.9.2	Processes are in place for managing a complaint or concern about a member of staff, including contracted staff and volunteers, and there is evidence they have been used.	SM	SM

Employee support and workplace relations

Action	Description	Organisation's self-rating	Surveyor Rating
13.10.1	The workplace rights and responsibilities of management, staff and volunteers are clearly defined and communicated.	SM	SM
13.10.2	Managers take action on at-risk behaviour of staff and volunteers.	SM	SM
13.11.1	There is a consultative and transparent system to identify, manage and resolve workplace relations issues which is evaluated, and improved as required.	SM	SM
13.12.1	Strategies to: • motivate staff • acknowledge the value of staff • support flexible work practices are evaluated with staff participation, and improved as required.	N/A	N/A
13.13.1	Performance measures are used regularly to assess staff access to an employee assistance program and to evaluate the staff support services, and improvements are made as required.	SM	SM

Information Management

Health records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.1.1	Health records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability • the secure, safe and systematic storage and transport of data and records • timely and accurate retrieval of records stored on or off site, or electronically • apprpriate retention and destruction of records • training for relevant staff in health records management.	SM	SM
14.2.1	The system for the allocation and maintenance of the organisation-specific consumer / patient identifier, including a process for checking multiple identifiers, is evaluated, and improved as required.	SM	SM
14.3.1	Healthcare workers participate in the analysis of data including clinical classification information.	SM	SM
14.3.2	Clinical coding and reporting time frames that meet internal and external requirements are evaluated, and improved as required.	SM	SM
14.4.1	Consumers / patients are given advice / written guidelines on how to access their health information, and requests for access are met.	SM	SM

Corporate records management

Action	Description	Organisation's self-rating	Surveyor Rating
14.5.1	Corporate records management systems are evaluated to ensure that they include: • reference to all relevant legislation / standards / policy / guidelines • defined governance and accountability	SM	SM

• the secure, safe and systematic storage and transport of data and records
• standardised record creation and tracking
• appropriate retention and destruction of records
• training for relevant staff in corporate records management.

Collection, use and storage of information

Action	Description	Organisation's self-rating	Surveyor Rating
14.6.1	Monitoring and analysis of clinical and non-clinical data and information occur to ensure: • accuracy, integrity and completeness • the timeliness of information and reports • that the needs of the organisation are met and improvements are made as required.	SM	SM
14.6.2	The information management system is evaluated to ensure that it includes: • identification of the needs of the organisation at all levels • compliance with professional and statutory requirements for collection, storage and use of data • the validation and protection of data and information • delineation of responsibility and accountability for action on data and information • adequate resourcing for the assessment, analysis and use of data • data storage and retrieval facilitated through effective classification and indexing • contribution to external databases and registers • training of relevant staff in information and data management.	SM	SM
14.7.1	The organisation uses data from external databases and registers for: • research • development • improvement activities • education • corporate and clinical decision making • improvement of care and services.	SM	SM
14.8.1	Staff have access to contemporary reference and resource material.	SM	SM

Information and communication technology

Action	Description	Organisation's self-rating	Surveyor Rating
14.9.1	The ICT system is evaluated to ensure that it includes: • backup • security • redundancy • protection of privacy • virus detection • preventative maintenance and repair • disaster recovery / business continuity	SM	SM

	• risk and crisis management • monitoring of compliance with ICT policy and procedures.		
14.9.2	Licences are purchased as required to ensure intellectual property rights and title to products are retained by product owners.	SM	SM

Corporate Systems and Safety

Strategic and operational planning

Action	Description	Organisation's self-rating	Surveyor Rating
15.1.1	The strategic plan that: • includes vision, mission and values • identifies priority areas for care, service delivery and facility development • considers the most efficient use of resources • includes analysis of community needs in the delivery of services • formally recognises relationships with relevant external organisations is regularly reviewed by the governing body.	SM	SM
15.1.2	Leaders and managers act to promote a positive organisational culture.	SM	SM
15.1.3	Operational plans developed to achieve the organisation's goals and objectives and day-to-day activities comply with appropriate by-laws, articles of association and/or policies and procedures.	SM	SM
15.2.1	Changes driven by the strategic plan are communicated to, and evaluated in consultation with, relevant stakeholders.	N/A	N/A
15.2.2	Change management strategies are implemented to achieve the objectives of the strategic and operational plans.	N/A	N/A

Systems and delegation practices

Action	Description	Organisation's self-rating	Surveyor Rating
15.3.1	The processes of governance and the performance of the governing body are evaluated to ensure that they include: • formal orientation and ongoing education for members of the governing body • defined terms of reference, composition and procedures for meetings of the governing body • communication of information about governing body activities and decisions with relevant stakeholders • defined duties and responsibilities and a role for strategy and monitoring.	SM	SM
15.4.1	Compliance with delegations is monitored and evaluated, and improved as required.	SM	SM
15.5.1	Organisational structures and processes are reviewed to ensure that quality services are delivered.	N/A	N/A
15.6.1	There is evidence of evaluation and improvement of the system to govern and document decision making with ethical implications, which includes: • a nominated consultative body • a process to receive, monitor and assess issues • review of outcomes.	SM	SM

15.7.1	Organisational committees: • have access to terms of reference, membership and procedures • record and confirm minutes and actions of meetings • implement decisions and are evaluated and improved as required.	SM	SM
15.8.1	The organisation has sound financial management processes that: • are consistent with legislative and government requirements • include budget development and review • allocate resources based on service requirements identified in strategic and operational planning • ensure that useful, timely and accurate financial reports are provided to the governing body and relevant managers • include an external audit.	SM	SM

External Service Providers

Action	Description	Organisation's self-rating	Surveyor Rating
15.9.1	There is evidence of evaluation and improvement of systems to manage external service providers, which: • are governed by implemented policy and procedure • include documented service agreements • define dispute resolution mechanisms • monitor compliance of service providers with relevant regulatory requirements and specified standards • require evidence from service providers of internal evaluation of the services they provide • ensure that external service providers comply with organisational policy and procedures.	SM	SM
15.9.2	The organisation evaluates the performance of external service providers through agreed performance measures, including clinical outcomes and financial performance where appropriate, and improvements are made as required.	N/A	N/A

Research Governance

Action	Description	Organisation's self-rating	Surveyor Rating
15.10.1	The system that: • determines what research requires ethical approval • oversees the ethical conduct of organisational research • monitors the completion of required reporting is evaluated and improved as required.	SM	SM
15.10.2	Consumers and researchers work in partnership to make decisions about research priorities, policy and practices.	SM	SM
15.11.1	Systems are implemented to effectively govern research through policy / guidelines consistent with: • jurisdictional legislation • key NHMRC statements • codes of conduct • scientific review standards.	SM	SM
15.11.2	The governance of research through: • documented accountability and responsibility	SM	SM

	• establishing formal agreements with collaborating agencies • adequately resourcing the organisation's human research ethics committee (HREC), where applicable is evaluated, and improved as required.		

Safety management systems

Action	Description	Organisation's self-rating	Surveyor Rating
15.12.1	Safety management systems include policies and procedures for: • work health and safety (WHS) • manual handling • injury management • management of dangerous goods and hazardous substances • staff education and training in WHS responsibilities.	SM	SM
15.13.1	The system for ensuring WHS includes: • identification of risks and hazards • documented safe work practices / safety rules for all relevant procedures and tasks in both clinical and non-clinical areas • staff consultation • staff education and provision of information • an injury management program • communication of risks to consumers / patients and visitors and is implemented, evaluated, and improved as required.	SM	SM
15.13.2	Staff with formal WHS responsibilities are appropriately trained.	SM	SM
15.13.3	A register of dangerous goods and hazardous substances is maintained and Material Safety Data Sheets (MSDSs) are available to staff.	SM	SM
15.14.1	There is evidence of evaluation and improvement of the radiation safety management plan, which: • is coordinated with external authorities • includes radiation equipment, a register for all radioactive substances, and safe disposal of all radioactive waste • ensures staff exposure to radiation is kept as low as reasonably achievable (ALARA) • keeps consumer / patient radiation to a minimum whilst maintaining good diagnostic quality • includes a personal radiation monitoring system and any relevant area monitoring.	SM	SM

Buildings, plant and equipment

Action	Description	Organisation's self-rating	Surveyor Rating
15.15.1	The procurement, management, risk reduction and maintenance system includes: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables	SM	SM

	• workplace design.		
15.15.2	Plant and other equipment are installed and operated in accordance with manufacturer specifications, and plant logs are maintained.	SM	SM
15.16.1	Incidents and hazards associated with: • buildings / workplaces • plant • medical devices / equipment • other equipment • supplies • utilities • consumables are documented and evaluated, and action is taken to reduce risk.	SM	SM
15.16.2	The safety and accessibility of buildings / workplaces, and the safe and consistent operation of plant and equipment, are evaluated, and improvements are made to reduce risk.	SM	SM
15.17.1	Access to the organisation is facilitated by: • clear internal and external signage • the use of relevant languages and multilingual / international symbols • the provision of disability access • facility design that meets legislative requirements and/or is based on recognised guidelines.	SM	SM

Emergency and disaster management

Action	Description	Organisation's self-rating	Surveyor Rating
15.18.1	There is evidence of evaluation and improvement of the emergency and disaster management systems, which include: • identification of potential internal and external emergencies and disasters • coordination with relevant external authorities • installation of an appropriate communication system • development of a response, evacuation and relocation plan • display of relevant signage and evacuation routes • planning for business continuity.	SM	SM
15.19.1	There is evidence of evaluation and improvement of staff training and competence in emergency procedures, which includes: • education at orientation • annual training in emergency, evacuation and relocation procedures • regularly conducted emergency practice / drill exercises • the appointment of an appropriately trained fire officer • access to first aid equipment and supplies, and training of relevant staff.	SM	SM
15.20.1	There is documented evidence that an authorised external provider undertakes a full fire report on the premises at least once within each EQuIPNational cycle and/or in accordance with jurisdictional legislation.	SM	SM
15.20.2	There is a documented plan to implement recommendations from the fire inspection.	SM	SM

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Physical and personal security

Action	Description	Organisation's self-rating	Surveyor Rating
15.21.1	Service planning includes strategies for security management.	SM	SM
15.21.2	The organisation-wide system to identify and assess security risks, determine priorities and eliminate risks or implement controls is evaluated, and improved as required.	SM	SM
15.22.1	Staff are consulted in decision making that affects organisational and personal risk and are informed of security risks and responsibilities.	SM	SM
15.22.2	Security management plans are coordinated with relevant external authorities.	SM	SM
15.23.1	The violence and aggression management plan is evaluated to ensure that it includes: • policies / procedures for the minimisation and management of violence and aggression • staff education and training • appropriate response to incidents.	SM	SM

Waste and environmental management

Action	Description	Organisation's self-rating	Surveyor Rating
15.24.1	The waste and environmental management system is evaluated to ensure that it includes: • development and implementation of policy • coordination with external authorities • staff instruction and provision of information on their responsibilities.	SM	SM
15.25.1	Controls are implemented to manage: • identification • handling • separation and segregation of clinical, radioactive, hazardous and non-clinical waste, and the controls are evaluated, and improved as required.	SM	SM
15.26.1	The system to: • increase the efficiency of energy and water use • improve environmental sustainability • reduce carbon emissions is evaluated and improved as required.	SM	SM

EQuIPNational Interim Accreditation

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Recommendations from Current Survey

Nil

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Recommendations from Previous Survey

Nil

EQuIPNational Interim Accreditation

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Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	36	8	44
Standard 2	0	3	1	4
Standard 3	0	31	8	39
Standard 4	0	23	8	31
Standard 5	0	6	3	9
Standard 6	0	6	3	9
Standard 7	0	13	7	20
Standard 8	0	15	5	20
Standard 9	0	12	3	15
Standard 10	0	13	5	18
Total	**0**	**158**	**51**	**209**

Standard	SM	MM	Total
Standard 1	36	0	36
Standard 2	3	0	3
Standard 3	31	0	31
Standard 4	23	0	23
Standard 5	6	0	6
Standard 6	6	0	6
Standard 7	13	0	13
Standard 8	15	0	15
Standard 9	12	0	12
Standard 10	13	0	13
Total	**158**	**0**	**158**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	8	1	9
Standard 2	0	4	7	11
Standard 3	0	0	2	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	1	1	2
Standard 7	0	3	0	3
Standard 8	0	3	1	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**35**	**12**	**47**

Standard	SM	MM	Total
Standard 1	8	0	8
Standard 2	4	0	4
Standard 3	0	0	0
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	1	0	1
Standard 7	3	0	3
Standard 8	3	0	3
Standard 9	8	0	8
Standard 10	2	0	2
Total	**35**	**0**	**35**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	44	9	53	Met
Standard 2	0	7	8	15	Met
Standard 3	0	31	10	41	Met
Standard 4	0	29	8	37	Met
Standard 5	0	6	3	9	Met
Standard 6	0	7	4	11	Met
Standard 7	0	16	7	23	Met
Standard 8	0	18	6	24	Met
Standard 9	0	20	3	23	Met
Standard 10	0	15	5	20	Met
Total	**0**	**193**	**63**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	44	0	44	Met
Standard 2	7	0	7	Met
Standard 3	31	0	31	Met
Standard 4	29	0	29	Met
Standard 5	6	0	6	Met
Standard 6	7	0	7	Met
Standard 7	16	0	16	Met
Standard 8	18	0	18	Met
Standard 9	20	0	20	Met
Standard 10	15	0	15	Met
Total	**193**	**0**	**193**	**Met**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Organisation - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	1	1	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**23**	**1**	**24**

Standard	SM	MM	Total
Standard 11	1	0	1
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**23**	**0**	**23**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	12	2	14
Standard 12	0	13	1	14
Standard 13	0	15	3	18
Standard 14	0	11	0	11
Standard 15	0	26	4	30
Total	**0**	**77**	**10**	**87**

Standard	SM	MM	Total
Standard 11	12	0	12
Standard 12	13	0	13
Standard 13	15	0	15
Standard 14	11	0	11
Standard 15	26	0	26
Total	**77**	**0**	**77**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	13	3	16	Met
Standard 12	0	23	1	24	Met
Standard 13	0	17	3	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	35	4	39	Met
Total	**0**	**100**	**11**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	13	0	13	Met
Standard 12	23	0	23	Met
Standard 13	17	0	17	Met
Standard 14	12	0	12	Met
Standard 15	35	0	35	Met
Total	**100**	**0**	**100**	**Met**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	36	8	44
Standard 2	0	3	1	4
Standard 3	0	31	8	39
Standard 4	0	23	8	31
Standard 5	0	6	3	9
Standard 6	0	6	3	9
Standard 7	0	13	7	20
Standard 8	0	15	5	20
Standard 9	0	12	3	15
Standard 10	0	13	5	18
Total	**0**	**158**	**51**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	8	1	9
Standard 2	0	4	7	11
Standard 3	0	0	2	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	1	1	2
Standard 7	0	3	0	3
Standard 8	0	3	1	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**35**	**12**	**47**

Standard	SM	MM	Total
Standard 1	36	0	36
Standard 2	3	0	3
Standard 3	31	0	31
Standard 4	23	0	23
Standard 5	6	0	6
Standard 6	6	0	6
Standard 7	13	0	13
Standard 8	15	0	15
Standard 9	12	0	12
Standard 10	13	0	13
Total	**158**	**0**	**158**

Standard	SM	MM	Total
Standard 1	8	0	8
Standard 2	4	0	4
Standard 3	0	0	0
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	1	0	1
Standard 7	3	0	3
Standard 8	3	0	3
Standard 9	8	0	8
Standard 10	2	0	2
Total	**35**	**0**	**35**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	44	9	53	Met
Standard 2	0	7	8	15	Met
Standard 3	0	31	10	41	Met
Standard 4	0	29	8	37	Met
Standard 5	0	6	3	9	Met
Standard 6	0	7	4	11	Met
Standard 7	0	16	7	23	Met
Standard 8	0	18	6	24	Met
Standard 9	0	20	3	23	Met
Standard 10	0	15	5	20	Met
Total	**0**	**193**	**63**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	44	0	44	Met
Standard 2	7	0	7	Met
Standard 3	31	0	31	Met
Standard 4	29	0	29	Met
Standard 5	6	0	6	Met
Standard 6	7	0	7	Met
Standard 7	16	0	16	Met
Standard 8	18	0	18	Met
Standard 9	20	0	20	Met
Standard 10	15	0	15	Met
Total	**193**	**0**	**193**	**Met**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Surveyor - EQuIPNational

Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	1	1	2
Standard 12	0	10	0	10
Standard 13	0	2	0	2
Standard 14	0	1	0	1
Standard 15	0	9	0	9
Total	**0**	**23**	**1**	**24**

Standard	SM	MM	Total
Standard 11	1	0	1
Standard 12	10	0	10
Standard 13	2	0	2
Standard 14	1	0	1
Standard 15	9	0	9
Total	**23**	**0**	**23**

Non-Mandatory

Standard	Not Met	Met	N/A	Total
Standard 11	0	12	2	14
Standard 12	0	13	1	14
Standard 13	0	15	3	18
Standard 14	0	11	0	11
Standard 15	0	26	4	30
Total	**0**	**77**	**10**	**87**

Standard	SM	MM	Total
Standard 11	12	0	12
Standard 12	13	0	13
Standard 13	15	0	15
Standard 14	11	0	11
Standard 15	26	0	26
Total	**77**	**0**	**77**

EQuIPNational Interim Accreditation

Organisation : Northern Beaches Hospital
Orgcode : 126924

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 11	0	13	3	16	Met
Standard 12	0	23	1	24	Met
Standard 13	0	17	3	20	Met
Standard 14	0	12	0	12	Met
Standard 15	0	35	4	39	Met
Total	**0**	**100**	**11**	**111**	**Met**

Standard	SM	MM	Total	Overall
Standard 11	13	0	13	Met
Standard 12	23	0	23	Met
Standard 13	17	0	17	Met
Standard 14	12	0	12	Met
Standard 15	35	0	35	Met
Total	**100**	**0**	**100**	**Met**