NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Lady Davidson Private Hospital

Nth Turramurra, NSW

Organisation Code: 110112
Health Service Facility ID: 100984
Assessment Date: 27/08/2019 to 29/08/2019

Accreditation Cycle: 1

Contents

Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
Met	All requirements of an action are fully met.
Met with Recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low.
Risk ratings are:

1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: **low** risk; manage by routine procedures

Executive Summary

Introduction

Lady Davidson Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 27/08/2019 to 29/08/2019. The NS2 OWA required 2 assessors for a period of 3 day(s). Lady Davidson Private Hospital is a Private organisation. Lady Davidson Private Hospital was last assessed between 23/08/2016 to 25/08/2016. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Lady Davidson Private Hospital	100984

General Discussion

Lady Davidson Private Hospital (LDPH) is a 115-bed private rehabilitation facility and is part of the Healthscope group of hospitals. It is situated at North Turramurra on Sydney's Upper North Shore and continues to be a dedicated Registrar training hospital for Rehabilitation Medicine.

A comprehensive pre-assessment account of systems and processes for quality and safety across all eight National Standards was provided. Assessors visited all clinical areas, met with the LDPH Executive team, senior managers and VMO members of the Medical Advisory Committee.

Assessors noted that staff were uniformly very proud of their organisation, valuing their high team spirit and the numerous opportunities for training and professional development and promotion within the organisation.

All previous recommendations have been closed. Actions 1.27, 4.10, 6.2 and 8.6 are assessed as Met with Recommendation and recommendations have been made.

Standard 1

The Healthscope clinical governance systems to improve safety and quality of care for patients are well established in LDPH. Similarly, the corporate integrated risk management system uses RiskMan to report incidents, near misses, complaints and sentinel events is evident.

The Healthscope Aboriginal and Torres Strait Islander Reconciliation Action Plan (RAP) has been implemented. Significant effort continues to be taken to collaborate with the Aboriginal community to strengthen relationships and ensure that LDPH is culturally welcoming.

The quality and safety management system are well defined and comprehensive.

Since the implementation of the Board and Executive approved 'Back to the Bedside' project in April 2018 patient and consumer feedback has been enhanced through consistent use of the Acknowledge, Introduce, Duration, Explanation and Thank You (AIDET) communication process, regular rounding of patient, clinical bedside handover involving patients, use of individual patient care boards.

Observed systems and process indicate that the workforce has the right qualifications, skills and supervision to provide safe, high quality health care.

Healthcare records are governed and managed consistently with appropriate policies and procedures and are easily accessible to all clinical staff at the point of care. LDPH has an implementation plan to provide clinical information into the My Health Record system.

Whilst most policies and procedures sighted were appropriately referenced to evidence-based practice, there is an observed need to review current nursing practice to identify areas not congruent with current best practice. Consequently, there is a Met with Recommendation for Action 1.27.

Site managers schedule and plan maintenance, testing and tagging, emergency generators, and infrastructure site inspections to ensure compliance with Australian Standards and legislation including Work Health and Safety. Assessors found signage to be clear and appropriate.

Standard 2

Systems and processes are designed to ensure the patient and carers are at the centre of care, planning, improvements and evaluations. There is a Consumer Advisory Group that provides input into the governance, leadership and management committees. Across LDPH, assessors evidenced systems and processes in place to support patient and their carer involvement in care planning. LDPH ensures that the consumer information developed by the organisation meets the needs of the patient by having the brochures and posters reviewed at the appropriate Consumer Advisory Groups through either Healthscope or LDPH.

Standard 3

Effective governance and safety and quality systems for the prevention and control of healthcare-associated infections and promotion of antimicrobial stewardship are well established. A multidisciplinary Infection Control Committee (ICC) meets bi-monthly. Infection control incidents, complaints and near misses, clinical audit outcomes and associated improvements are also reported and discussed at Consumer Advisory, Patient Care Review and Senior Managers Committees. Incidents of Hospital acquired infections is noted to be very low. Surveillance systems are appropriate. Continual improvement in compliance with the Hand Hygiene program demonstrates organisational commitment to prevention of healthcare associate infections with most recent facility wide rate of 91% compliance achieved.

An Antimicrobial Stewardship (AMS) Program is in place governed by the AMS Committee, a subcommittee of the Infection Control Committee.

Standard 4

The risks associated with medication management are understood and the related policies and procedures clearly articulate best practice of medication and related risk management. Processes are in place to maximise the opportunity for obtaining a Best Possible Medication History. All drugs are secured and stored consistent with relevant applicable legislation, Healthscope and LDPH policy and procedures. During assessment, several medication charts in patient health records were observed to not have generic drug name, were incomplete or illegible. Consequently, Action 4.10 is assessed as Met with Recommendation.

Standard 5

The Clinical Governance Framework clearly articulates the safety and quality systems, roles, responsibilities and processes to support comprehensive care across LDPH. Policies and procedures reviewed by assessors, support the implementation of comprehensive care, the management of risks and facilitate workforce training to support implementation of comprehensive care across the organisation. Screening tools have been standardised. Information on Aboriginal and Torres Strait Islander (ATSI) origin is collected on admission. Planning for discharge commences on admission. Transfer of care is monitored, and escalation processes are in place.

Standard 6

There is a comprehensive suite of policies, procedures and guidelines governing clinical communication. During the assessment, multiple handovers and patient interactions were observed by assessors where patients and families, where appropriate, were involved in goal setting, shared decision-making, care planning and assessment of progress. There are identified opportunities to increase compliance with policy, guidelines and procedures related to correct patient identification, procedure matching and approved identifiers, were evident. Consequently, Action 6.2 is Met with a Recommendation to ensure compliance with Healthscope Policy.

Standard 7

Relevant policies and procedures are in place and able to be accessed by all staff. Consent for blood and blood products is actively sought and obtained. Adverse events are reported consistent with national guidelines and data fed into ACHS clinical indicators. There have been no reported adverse outcomes relating to blood transfusions since 2014. The storage, distribution and tracing of blood and blood products is well governed and managed consistently. There are identified opportunities to strengthen the governance of blood transfusion processes that were discussed during the assessment. Consequently, several suggestions have been made to enable this to occur.

Standard 8

There is a comprehensive set of policies and procedures at both Healthscope and LDPH level governing recognising and responding to acute deterioration. All Rapid Response Team and Code Blue incidents are reported on the RiskMan system and regularly reviewed to identify required improvements. There is no capacity to provide advanced life support (ALS) at LDPH and response by NSW Ambulance Service is relied on for Advanced Life Support and transfer to an acute facility. LDPH provides consumer information empowering patients, carers or families to directly escalate care within the hospital's patient information directory and on the Patient Care Board at the end of each ward bed.

Summary of Results

Lady Davidson Private Hospital achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

Lady Davidson Private Hospital achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

Further details and specific performance to all of the actions within the standards is provided over the following pages.

Lady Davidson Private Hospital

Sites for Assessment

Sites for Assessment - Lady Davidson Private Hospital

Lady Davidson Private Hospital HSF ID:100984	
Address: 434 Bobbin Head Road NTH TURRAMURRA NSW 2074	Visited: Yes

Lady Davidson Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

Action 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Healthscope clinical governance framework endorsed by the Healthscope Board is used by the Lady Davidson Private Hospital (LDPH) General Manager and the Senior Management team to develop, lead, support and monitor a positive culture of partnership in the delivery of safe and high quality of care for patients and consumers. The LDPH Clinical Governance Safety and Quality Plan is aligned to the Healthscope Safety and Quality and Strategic Plans. The current LDPH strategic plan was developed in March 2019 in consultation with consumer representatives and managers to reflect the Healthscope Strategic Plan, vision, values, strategic aims, purpose and priority areas for clinical outcomes and exceptional patient care. An extensive senior leadership program has been planned to strengthen the leadership capability for senior leaders working in LDPH which is a very timely and positive strategy identified in the current strategic plan.

LDPH is situated on the Darramuragal People's land. The Healthscope Aboriginal and Torres Strait Islander Reconciliation Action Plan (RAP) has been used to develop staff knowledge and understanding of the needs of Aboriginal and Torres Strait Islander patients. Demographic data indicates 0.1269% of admissions identify as either Aboriginal and/or Torres Strait Islander. An eLearning program for senior managers and administration staff is used to ensure all patients are asked the question "are you of Aboriginal or Torres Strait Island descent?" Evidence provided included the Healthscope commissioned art work by a Warthaurong man Stan Yarramuna which is hung in the hospital's entrance; a map of Australia identifying the many Aboriginal Torres Strait dialectics; and a display of the Australian, Aboriginal and Torres Strait Flags in all clinical areas; financial contribution to the Darwin based Purple House and Truck project; plans for a smoking ceremony "Welcome to Country" to celebrate the LDPH 100th Birthday in August 2020. Advisory 18/04 is fully met for Actions 1.2, 1.4, 1.21 and 1.33.

Comprehensive reporting to the Healthscope governing body occurs regarding safety and quality indicators (KPIs) and actions taken as a result of analysis of under-performance and critical incidents. These KPIs are also reported to the Consumer Advisory, Patient Care Review, Quality and Risk Committee and the Senior Management Committee. Terms of Reference are included in the regular evaluation of Committee function and performance.

Staff and VMOs were able to articulate their understanding of the clinical governance systems and their roles, responsibilities and accountabilities for safety and quality as defined in their position descriptions, By-Laws, reporting lines and their experience with annual performance reviews and peer review processes.

Patient safety and quality systems

Action 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

There is a comprehensive set of policies and procedures at both Healthscope and LDPH level that link closely with and rely on the clinical governance framework thus ensuring that associated risks are recognised, documented and managed appropriately. The LDPH Quality Manager is the document controller responsible for coordination of the development, review distribution/communication and archiving of policies. Staff and clinicians, throughout the assessment, demonstrated their ability to access requested policies through the Healthscope Intranet (HINT). Compliance with policy is monitored through annual audits, and analysis of reported incidents.

Quality and safety management system are well defined and comprehensive to comply with Healthscope requirements for regular monitoring of patient clinical outcomes including patient feedback through the Qualtrics patient experience process. A Risk Adjusted Hospital Acquired Complication (HAC) rate is reported quarterly to Healthscope. The LDPH Quality and Safety Plan outlines the comprehensive Healthscope organisation wide quality system focus for Monitoring, Reducing Risk and Continuous Improvement, designed to produce data that is timely and well-monitored and actioned as required to ensure areas of under-performance are addressed. These improvement actions form part of the organisations Quality Action Plan generated through the RiskMan tool. Participation in the Healthscope National Quality Management System through this quarterly KPI reporting, the established process for shared learnings and participation in relevant Healthscope Webex forums enhances the identification for potential continuous improvement. Consumer involvement in the review of safety and quality performance and systems is through the Consumer Advisory Committee. The LDPH MyHealthscope – Quality and Safety performance outcome data with relevant explanatory consumer information, is publicly available.

The Healthscope integrated risk management system which has a state-of-the-art customised version of RiskMan which is well established through a comprehensive collection and classification of risk rated data and ability for managers and staff to analyse and treat or mitigate an identified risk. The risk register is generated through RiskMan and used to monitor and reduce the level of risk for the organisation. All risks are numbered and have a clearly identified owner to ensure tracking of risks is transparent. Staff were able to describe the risk management system and their role in reporting incidents, identified hazards and the potential key risks in their work areas. Whilst the assessors were able to track individual risks within the risk register it was difficult to link an identified risk with a corresponding quality improvement initiative in the quality action plan as the latter is only identified by the source rather than date commenced or reference number, consequently a suggestion has been made.

There is a comprehensive organisation wide incident reporting and investigation system that is appropriately designed, resourced and regularly monitored and strengthened by Healthscope. An extensive suite of corporate policies is available on the intranet (HINT) website to support the workforce to recognise and report incidents and where relevant complete an open disclosure. Training programs for managers and staff are evident. RiskMan is used to report incidents, near misses, complaints and sentinel events. Email notification of reported incidents to department managers, quality managers and the executive team, whilst serious incidents for example sentinel events, are elevated verbally and by email through the Healthscope chain of command alert system. Opportunities for quality improvement initiatives at a local or national level are identified based on trend in incidents.

Since the implementation of the Board and Executive approved 'Back to the Bedside' project in April 2018 patient and consumer feedback has been enhanced through consistent, regular rounding of patient, clinical bedside handover involving patients, use of individual patient care boards. Patients are surveyed electronically soon after their discharge using the Australian Hospital Patient Experience Question Set (AHPEQS). Hospital Executive, Quality Manager and Department Heads can access their survey results via the Healthscope electronic Patient Experience Portal (Qualtrics) allowing them to share results with staff, analyses result and identify opportunities for improvement. Trend graphs of patient experience commenced in early 2018 indicate increasing positive results up to 92.3% satisfaction in July 2019 which is outstanding.

Patients, families and carers are provided with information on how to submit a complaint on admission and in the patient information directory at the bedside, LDPH website, Healthscope website 'Contact page' or through the recently introduced Patient Care Boards in the patient room. Complaints management is coordinated from the Executive office and is in accordance with Healthscope Policy 1.08 and relevant legislation. Open Disclosure training for relevant staff (n=173) is currently at 97%. LDPH diversity profile with gender and age is reflective of the admission profile. The predominant language spoken at home remains English. Detailed risk assessments on admission identify patients who are predisposed to a higher risk of harm.

The healthcare record at LDPH is hard copy. Pathology and imaging are available electronically for viewing with a hard copy always filed.

Healthcare records are governed and managed consistently with standards. Appropriate policies and procedures are well established, at both corporate and local levels, and are easily accessible to staff. The healthcare record is easily accessible to all staff with clearly understood processes in place if access is required out-of-hours. There is an annual documentation audit undertaken. The 2018 audit had an overall compliance of 90.66% with areas identified for improvement, including compliance with policy requirements for telephone orders by nursing and medical staff and ongoing opportunities for improving medical documentation including legibility. There is no process in place to assess and evaluate the accuracy and completeness of documentation by clinicians. Assessors discussed the importance of using a documentation content audit that will be beneficial for ongoing assessment and evaluation of evidenced based practice. The healthcare records are stored securely in all areas with staff well aware of privacy requirements.

At admission, consent is sought from all patients to upload records (event summary and nursing discharge summary) and the upload is completed at discharge. With respect to Advisory 18/11 LDPH is well progressed and exceeding the timelines required in this Advisory.

Suggestions for Improvement:

There is an opportunity to enhance the processes for documenting quality action initiatives by dating each entry, using an identifier/reference number and where relevant, recording the related RiskMan generated incident number to facilitate a timely integration between an identified risk and resulting quality improvement initiative.

It is suggested that a documentation audit process be regularly used to assess and evaluate the appropriateness and effectiveness of the continuity of the patient care journey.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	

Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Education for new employees and existing staff regarding safety and quality is thorough. There are established orientation and mandatory education programs. Evidence sighted indicated that there was greater than 92% compliance with all designated mandatory training.

Healthscope policies define workforce performance review process which focus on governance compliance, professional goals, educational needs and compliance with mandatory training and competency assessment. Evidence provided indicate that 94% (n= 254) of staff have had recent performance review.

There are systems and process in place to define, monitor and review scope of practice for all clinicians. The Medical Advisory Committee (MAC) acts as the credentialing authority for the all medical officers in accordance with the Healthscope By-Laws for VMOs and Allied Health staff. VMO scope of practice is retained in the cGov Doctor eCredentialing System and is available to relevant LDPH staff through the webPAS system. Both credentialing and scope of practice for VMOs is closely monitored and reported in the Healthscope quarterly KPIs with a target of 100% compliance. Nursing and Allied Health scope of practice and required registration is stated in position descriptions and monitored through medical record documentation of signature and role designation and through the Australian Health Practitioner Regulation Agency (AHPRA) for registration.

Healthscope policy 2.32 New Interventional Procedures is used if required, to ensure compliance with credentialing, equipment selection, medical and staff training, environmental and redesign requirements.

Processes are in place to maximise the opportunity for staff to understand and perform their roles and responsibilities for safety and quality. Assignment of safety and quality roles for responsibilities, the workforce, including agency, is through position descriptions, orientation, eLearning training packages, regular feedback and supervision as required. Supernumerary periods for new staff with access to preceptors is available as required.

The workforce including clinicians have access to the intranet and the Healthscope librarian (on site at LDPH) for clinical guidelines and standards including ACSQHC Clinical Care Standards that are relevant and current to the ACQSHC National Standards and the scope of clinical practice in LDPH.

Delirium Clinical Care Standard, Venous Thromboembolism Clinical Care Standard, and the End-of-Life Consensus Statement are used to inform care.

There is an identified need for systems and processes to monitor variation in current nursing practice in accordance with evidenced based practice. Consequently, Action 1.27 is Met with Recommendation.

Clinical indicator, HAC and audit data outcomes are tabled at the Patient Care Review, Senior Management and MAC Committees.

Action 1.27

The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

Whilst most policies and procedures sighted were appropriately referenced to evidence-based practice, there is an observed need to review current nursing practice to identify areas not congruent with current best practice.

Recommendation:

Undertake a gap-analysis of the current use of documented clinical guidelines, evidence-based clinical pathways, decision support tools and clinical care standards to identify opportunities for improvement, monitoring and regular evaluation of clinicians use of best available evidence.

Risk Rating:

Low

Risk Comment:

Compliance with best practice is an important component of safe patient care.

Safe environment for the delivery of care

Action 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope procurement guidelines ensure that facilities embarking on design or re-design projects are equipped with the required processes to maximise safety and quality of care. The site manager schedules and plans maintenance, testing and tagging, emergency generators, biomedical equipment and infrastructure site inspections, to ensure compliance with Australian Standards and Legislation including Work Health and Safety. All incidents and hazards are reported into the RiskMan system.

Potential high-risk patients with unpredictable behaviour have been identified through Shared Learning opportunities facilitated by Healthscope.

Workforce education and training is aligned with risk and safety management systems with a focus on manual handling, violence and aggression training. Code Black training ("Personal Threat [Armed or Unarmed Persons Threatening Injury to Others or to Themselves], or illegal occupancy") has been added to the emergency procedures training. Staff duress buttons are located at all nursing stations and the front reception desk. The hospital is locked down at night.

Assessors found the signage to be clear and appropriate.

Flexible visiting arrangements are prompted through the hospital website.

Implementation of Healthscope Policy 1.03 Acknowledgement of Country includes acknowledging the Darramuragal People, at the commencement of the Consumer Advisory Committee and within the patient Information Directory and on the staff tele-information screens. Aboriginal Artwork is displayed at the entrance to the hospital.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Clinical governance is provided for partnering with consumers, using a background of Healthscope policies. Systems and processes are designed to ensure the patient and carers are at the centre of care. The Healthscope and LDPH policies, committee structure and strategic and operational plans all demonstrate partnering with consumers as a key element of the health service.

Consumers are engaged at all levels of the health service and at committee level in review of processes and outcomes. Consumers and volunteers with a range of experience and interests are members of the Consumer Advisory Committee (CAC) which meets 3-monthly. One consumer representative is a member of the Quality & Risk Committee. The committee minutes demonstrate involvement in decision-making, monitoring of outcomes and quality improvements and in some instance's delegation of decisions.

In 2018 an electronic patient experience feedback system using the Australian Hospital Patient Experience Question Set (AHPEQS) was implemented Healthscope wide. A recent consumer representative half yearly report describes actions taken in response to low levels of patient/consumer feedback due to the low level of patients with an email address which includes LDPH now offering paper and email surveys. Consideration is currently being given to having surveys available through the TV screen in the room with volunteers willing to assist patients use the technology to complete their patient experience surveys.

In recent patients' feedback, an aggregate of over 90% was reported for good and very good overall quality of treatment and care at LDPH; this was borne out by the responses of the patients who talked with assessors.

Consumers' consultants and volunteers are appropriately risk screened, trained and supported.

A comprehensive patient/consumer information package is provided at time of patient admission.

Suggestions for Improvement:

There is an opportunity to include consumers on more of the hospital's committees.

Partnering with patients in their own care

Action 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.5	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

The consumer representatives were very passionate about their role and contribution that they make. It was impressive to have feedback from consumer discussion with patients in the wards. There was the comment by the consumer representative that patients sometimes feel more comfortable discussing some issues with them.

Clinical bedside handover is conducted, and there are communication boards next to patients' bed.

In the consumer survey, patients were asked 'I was involved as much as I wanted in making decisions about my treatment and care' and 'I was kept informed as much as I wanted about my treatment and care' 93.8% was the response for both questions in July 2019.

The Functional Independent Measure (FIM) is a Rehabilitation tool to measure physical, mobility and cognitive overall ability on admission and is repeated on discharge as a measure of effective rehabilitation. It is one way of determining a person's ability to give consent.

Assessors evidenced systems and processes in place that support patients and their carers being involved in their care. This includes information on health care rights being readily available in public areas and at the point of care. Informed consent and informed financial consent are evidence based, compliant with legislation. These are well supported by policies and processes that are monitored and evaluated. Monitoring of these processes is through documentation audits communicated through the committee structure. Consumer Consultants have been involved in ensuring access and appropriateness of patient information which is available in multiple languages if required. The workforce is supported with education related to the requirements of consent. There are evidence-based processes in place to ensure patients and carers are well informed, to identify capacity and support consumers in the decision-making processes. These are monitored appropriately, and results are used to inform the improvement process.

Re Advisory AS18/10: The subjects of this advisory are Actions 2.4; LDPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Suggestions for Improvement:

Consider involving consumers in evaluating the process around ensuring patients are made aware of their health rights.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Consumer approved publications are available e.g. falls prevention and healthy diet for treatment of gout. Nursing and medical discharges are provided for patients, plus a comprehensive medication list. Clinical bedside handover includes the opportunity for the patient to be involved in the discussion about their care. Diversity with respect to other languages; For the 24 months prior to June 2019, languages spoken by the patients was audited, and found to be overwhelmingly English. Healthscope has forms in different languages, and translation services are available if required.

On the MyHealthscope website, LDPH publishes indicators that reflect the quality and safety of the hospitals.

Partnering with consumers in organisational design and governance

Action 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The CAC provides a good forum for involvement in governance and evaluation. In addition, the CAC is involved in the strategic planning process. The CAC members represent a diversity of experience and backgrounds. Department managers are encouraged to attend the CAC, and in June were part of the presentation and discussion concerning the strategic plan for LDPH.

Aboriginal and Torres Strait Islander (ATSI) focus: there is a display of commissioned artwork and a flag at the hospital; with smoking ceremony planned for 100th birthday next year, and there is a map in the hallway which shows ATSI dialects. There are flexible visiting hours, there an ATSI staff member and attempts have been made to include a local indigenous council member. There is a patient care guide from Queensland Health in the wards, as well as an ATSI patient care guideline. 2018 records show that 0.1269% of patients identified as ATSI, and as 16.5% of patients did not answer this question, there is an action plan in place to increase the number of patients who answer the identity question. A plan has also been developed regarding the increasing involvement of the Aboriginal community.

The community group who use the hydrotherapy pool were consulted re the design and made useful suggestions which were accepted. Recently, the hydrotherapy pool area was identified to require renovation. A forum was held with participants who made suggestions about individual change rooms, new lockers and a separate toilet. These were incorporated into the plans, and patient feedback has been positive because there are no longer queues for the change rooms, patient flow has improved, and valuables can be stored.

Suggestions for Improvement:

Including consumers in staff orientation could assist in incorporating their views and experiences into the training and education for the workforce.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Effective governance and safety and quality systems for the prevention and control of healthcare-associated infections and promotion of antimicrobial stewardship are well established through a contracted service with Healthcare Infection Control Management Resources (HICMR). The current Acting Infection Control Coordinator works closely with the Executive, the Infection Control Committee and the HICMR consultant to operationalise all infection prevention and control (IPC) activities.

HICMR risk-assessed policies and procedures for health-associated infections and antimicrobial stewardship are readily available to staff on the intranet. Additional Healthscope and local policies are available to cover specific areas not covered in other policies. Systems and processes for policy review and updating are appropriate. Access to eTherapeutic Guidelines is available for clinicians on all computers. Risks associated with healthcare associated infection and antimicrobial stewardship are regularly reviewed. Workforce training in IPC and antimicrobial stewardship is included within the mandatory training matrix, with related competency assessments undertaken, recorded and appropriately reported.

A multidisciplinary Infection Control Committee (ICC) meets bi-monthly and reports directly to the Executive, Patient Care Review and Medical Advisory Committees. The Antimicrobial Stewardship (AMS) and Hand Hygiene (HH) Committees report into the ICC.

Infection control incidents, complaints and near misses, clinical audit outcomes and associated improvements are also reported and discussed at Patient Care Review and Executive Management Committees. Hospital acquired infections and hand hygiene compliance are reported in the Healthscope quarterly KPI data and benchmarked against peer facilities. The LDPH Infection Control Risk Management Plan is updated annually, overseen by the IFC and approved by Executive team. Quality improvement is ongoing with several initiatives for continuous improvement to prevent and control healthcare associated infections were evident and evaluated regularly in line with this plan. LDPH has a representative on the Healthscope Webex Infection Control forum that has recently superseded the Cluster Committee. This team reviews relevant incidents, HAC rates, ACHS Clinical Indicators related to Hospital Acquired Infection (HAI), policies and best practice and contributes to organisation wide Shared Learnings.

Patient involvement in their care commences on admission with their completion of an infectious screening questionnaire used to determine care planning and appropriate accommodation. Hand hygiene posters adjacent to hand hygiene dispensers in high traffic areas and clinical entry and egress points along with multiple patient information brochures outlining infection prevention and control strategies for patients and families were evident. LDPH website and the MY Healthscope patient information is exemplary.

Surveillance systems are manual and rely on notification from the contracted on-site pathology practice. Results are reported at the ICC and reviewed and discussed before being made available to all department managers. Surveillance data for ACHS Infection Control Clinical Indicators (CI) and Healthscope Infection Control KPIs and Antimicrobial usage are collated, trended and benchmarked.

Infection prevention and control systems

Action 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Infection prevention and control is clearly a high priority for LDPH. Guidelines for standard and transmission-based precautions, consistent with the 2019 Australian Guidelines for Prevention and Control of Infection in Healthcare, are available for all clinical and non-clinical staff as required. Regular transmission-based precaution compliance audits have been enhanced with the introduction of Personal Protective Equipment (PPE) Caddies and Aseptic Active wipes. A nursing discharge/transfer summary, sent with all patients transferring to another healthcare facility or community nursing service, includes the patient infectious status. A LDPH site Pandemic Plan is available.

Continual improvement in compliance with the Hand Hygiene program demonstrates organisational commitment to prevention of healthcare associate infections with most recent facility wide rate of 91% compliance achieved, well above the Australian National benchmark of 80% and Healthscope target of greater than 85%. It is pleasing to see that medical compliance has continued to increase with a current compliance rate of 86% reflecting the increased awareness strategies applied by the Hand Hygiene Committee. Whilst HAI rates are low, minutes of meetings refer to a number of MRSA HAIs in 2018. Since the Hand Hygiene Committee has undertaken staff Hand and Nail audit, surveyed staff understanding and knowledge of best practice for hand hygiene, assessed patient feedback regarding staff cleaning their hands prior to providing care, the result of which mirror the less impressive results of hand hygiene audit results for before and after touching a patient.

Compliance with Healthscope Policy 8.38 Aseptic Technique training and competency assessment is impressive. Identified procedures requiring Aseptic Technique (AT) are clearly defined and used for AT observational audits of relevant clinical staff. Medical Officers are now included in the hospital wide AT audit. Education and audit results are reported to the ICC and Patient Care Review Committee.

Access to an expansive suite of Healthscope policies on Invasive Medical Devices that are consistent with the 2019 edition of Australian Guidelines for prevention and control of infection in healthcare is evident. Annual invasive device audit results good compliance.

Assessors observed LDPH to be very clean and aesthetically pleasing. There have been a range of initiatives in place to ensure compliance with Australian Guidelines for prevention and control of infection in healthcare including education and training opportunities and cleaning guidelines for environmental staff to use when cleaning patient care areas. Environmental cleaning is part of the Infection Control Plan with quarterly audits scheduled to assess the effectiveness of the environmental program.

Assessors note that improvements have been made in this area. Cleaning products are appropriately managed and safety data sheets are readily available. Supply of linen is contracted with regular meetings with the supply company to ensure compliance with AS/NZS4146:2000. A maintenance schedule for annual testing of the Thermal Mixing Valve (TMV) and Legionella (CFU) is managed by the Maintenance team with results reported immediately to the Infection Control Coordinator and tabled at the ICC. A legionella Control Risk Management plan was developed for LDPH and tabled at the ICC. There are no cooling towers in LDPH.

A workforce immunisation program consistent with the current national guidelines and NSW Health has been considerably enhanced by efforts from the ICC team taking 30% compliance in August 2018 up to greater than 90% compliance in July 2019. Staff uptake of the provided flu vaccination this year remains low which is disappointing given the huge effort undertaken by the Executive and the ICC team. Vaccine management and storage has been enhanced with the purchase in 2018 of a vaccine fridge with a built-in data logger. This fridge is on the generator backup system to ensure integrity of vaccines.

Suggestions for Improvement:

Consider undertaking unannounced observation audits of compliance with infection prevention guidelines for transmission-based precautions and hand hygiene practice to strengthen overall clinical practice in the prevention of HAIs.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is nil use of critical or semi critical reusable devices in LDPH. Prepacked sterile single use items are used as required. A detailed Gap Analysis for AS/NZ4187:2014 was observed to be fully compliant for the use of non-critical reusable medical items. Therapeutics Goods Administration (TGA) approved wipes are used for cleaning this equipment between patients. Therefore, Action 3.14 is rated as satisfactorily met in accordance with Advisory 18/07.

Antimicrobial stewardship

Action 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Antimicrobial stewardship (AMS) is monitored by the Antimicrobial Stewardship Committee which meets every second month. It reports through the Quality and Risk Co-coordinator to the Infection Control Committee, Medical Advisory Committee and hospital executive. Assessors were advised that there is access to an Infectious Diseases (ID) physician. An Antibiotic Stoplight reference guide is available in the wards for clinicians which reflects the restricted antibiotic policy.

LDPH participated in the National Antimicrobial Prescribing Survey (NAPS) in 2018, the results of which identified opportunities for improvement. One was the documentation of the review or stop date which was at 72.2%. However, on 13 May 2019 compliance with the specification on the medication chart of the length of the antibiotic course was 88%. The rate of documentation of clinical reason (or Indication) for prescribing antibiotics was 91.7% in the 2018 NAPS report. This audit is to be repeated in October 2019. There has been staff education with a special focus during Antibiotic Awareness Week in 2018.

Antibiotics are not on imprest but are dispensed from the HPS pharmacy. This provides the ability to carefully monitor antibiotic courses as they are individually dispensed. Requirements of Advisory AS18/08 are met.

Suggestions for Improvement:

Additional audits following up more of the NAPS results will strengthen the antimicrobial stewardship program.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

LDPH has a quarterly multidisciplinary Drug Advisory and Medication Safety Committee meeting that reports to the Patient Care Review and Medical Advisory Committees and the Hospital Executive. LDPH accesses Healthscope medication policies, and the policies and procedures sit within a legislative context and adhere to national and jurisdictional guidelines. There is evidence of monitoring of risks and medication incidents. The hospital has shown excellent leadership in medication safety by employing its own clinical pharmacists. In addition, a contracted HPS Pharmacy is on site to provide a prescription service for inpatients and discharge, which includes providing dose administration aids if required; The Director of Nursing has responsibility for ward imprest stock and Schedule Drugs.

Medication incidents and near misses are recorded in RiskMan, reviewed and action is taken. When required, the Clinical Educator and the Nurse Unit Manager meet with the person to discuss self-reflection and if need be, offer further training. When required, the Director of Medical Services communicates with the medical staff.

There is assessment of the medication management system, using medication safety audits, a National Standard Medication Chart (NSMC) audit and the Medication Safety Self-Assessment (MSSA) Tool; and local audits are performed.

Assessors were informed that a narcotic stewardship program is to be introduced in the near future.

Suggestions for Improvement:

It is suggested that the training programs such as Medication Management Plan (MMP) education be reviewed to ensure compliance with best practice prescribing guidelines, such as using generic names and using approved abbreviations as per the Australian Commission on Safety and Quality in Health Care 'Recommendations for terminology, abbreviations and symbols used in medicines documentation'.

It is suggested that one way of partnering with consumers is for the nurses to say the generic name of the medicine when they are administering it. This can assist the patient to recognise the name of the medicine they are taking and reduce the problem of doubling up on medications which can occur if brand names are used.

Schedule 8 registers should be numbered consecutively, and this should be regularly monitored.

Where a 'Signature' is required within the Schedules 8 and 4 Registers, staff should not use their 'initials' and the staff signature register in each ward should be kept up to date to enable appropriate monitoring of compliance with the Poisons Act (NSW) legislation.

Documentation of patient information

Action 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

An admission medication history is documented by nursing staff. As most patients are transferred from an acute hospital, the information from that source is used. For the patients who are admitted from home, nursing staff document the information, and the clinical pharmacist is contacted to have these patients as a priority, as the best possible medication history is often more difficult to verify.

A recent audit identified that the documentation of allergies in the medical record could be improved so that the information is consistent on all documents. It was noted by assessors that adverse drug reactions were not entered on all the patients' medication charts. Action plans should address these identified opportunities for improvement by the next audit period.

Suggestions for Improvement:

It is suggested that the admission medication history, in addition to the current medication chart is requested from the acute hospital transferring the patient to LDPH. This can assist with medication reconciliation, especially with respect to medications ceased prior to admission to that hospital, whether complementary and alternative medicines are documented in the admission medication history and if they are continuing, have been ceased or are to be restarted.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Patients and carers are given the opportunity to discuss medication at bedside handover daily. Medication reviews as identified on the MMP were signed on some charts.

The clinical pharmacists provide a comprehensive assessment of the patients' ability to manage their medications after discharge, and as well provide medication reconciliation for all planned discharge patients. At the completion of this, a current medication list (which includes reasons for change) is generated. Clinical pharmacists also liaise with health practitioners and carers taking over care of the patient post-discharge.

During assessment, several medication charts in patient health records were observed to have incomplete numbering or no numbering at all, which is a risk given that there were multiple charts being used simultaneously, due to the volume of medication prescriptions. Several written prescriptions were illegible, and the prescriber's identity could not be verified, as the prescriber details section of the chart had not been completed. Brand names only were used in the majority of charts, however the Clinical Pharmacist input into the identification of the generic name was evident. Consequently, Action 4.10 has been rated as Met with Recommendation and there is a recommendation to address these areas of non-compliance with the requirements of the NSMC documentation and the Poisons Act (NSW) legislation.

The HPS pharmacy provides blister packs for 28% of patients who are starting these for the first time when they leave hospital.

Education handouts are available for patients on relevant medication topics.

Suggestions for Improvement:

An audit of the pharmacist's pharmaceutical review on the medication chart would identify opportunities for increasing medication reconciliation, especially when the pharmacist has not completed the admission medication history.

It is suggested that staff further explore the NPS MedicineWise website for information for patients and their medication education.

Action 4.10

The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

Medication safety especially with respect to prescribing and medication charts needs to receive greater attention. A number of charts were reviewed during assessment. Some did not have full compliance with the requirements for legible orders, all medication charts to be numbered, legible signatures, generic names used and adverse drug reactions documented on all medication charts.

Recommendation:

Establish a process to regularly review and evaluate full compliance with best practice required in the use of the National Standard Medication Chart (NSMC) and action identified areas for improvement.

Risk Rating:

Moderate

Risk Comment:

Incomplete or illegible medication prescriptions can result in harm to the patient.

Medication management processes

Action 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Appropriate decision support tools are accessible through the intranet.

Medications were stored safely. There are monitored medication refrigerators and appropriate cold chain management. Unused, unwanted or expired medications are collected from the medication rooms by the HPS pharmacists, who take them back to their pharmacy and dispose of them in the return of unwanted medicines (RUM) bin in the pharmacy.

LDPH has reviewed and identified high risk medications and now has a PINCH listing relevant to the hospitals case mix profile. This includes increased restrictions for hydromorphone, which is rarely used, so there may be an increased opportunity for error.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

LDPH is governed by Healthscope and some local policies and procedures for comprehensive care. Quality Key Performance Indicator (KPI) data is reported to Healthscope head office, and the results of these submissions are benchmarked against other similar sized (peer groups) hospitals.

Incidents, Quality KPIs, Clinical Indicators (CI) and patient feedback are tabled for discussion and action if required which include system reviews, policy reviews, and education are discussed at the Quality and Risk Committee, other relevant clinical meetings as well as the Community Advisory Committee meeting. The General Manager, Director of Nursing and the Quality Manager receive email alerts for all clinical incidents at the time they are submitted; and all incidents are reviewed and investigated by the appropriate clinical manager.

It was noted that the average age of rehabilitation patients was higher at LDPH than at other Australian hospitals. Assessors were informed that many patients are admitted for investigation of falls with rehabilitation goals to increase balance and mobility. ACHS Clinical Indicator data indicates the percentage of patients developing pressure injuries was well below the industry rate and the falls rate is beginning to trend down since 2018.

Hospital acquired complications (HAC) data shows that LDPH is within the best practice index for all HACs related to comprehensive care.

Consumer survey results show a high satisfaction rate to the question ‘my views and concerns were listened to’, ‘I was involved as much as I wanted in making decisions about my treatment and care’ and ‘I was kept informed as much as I wanted about my treatment and care’.

The new Healthscope Comprehensive Care Plan, which will be introduced very soon, will result in the incorporation of several forms into the new comprehensive care plan. It will include information on shared decision-making and who is involved in the care, patient /carer education and discharge planning. The new comprehensive care plan-daily includes hygiene, mobility, fluid balance monitoring, nutrition/hydration, urinary elimination, patient/carer goal progression and investigations e.g. pathology.

An audit of the details recorded on the communications boards was undertaken. Sixty four percent (64%) of patients reported good communication for family and friends for the day ahead. An action plan has been developed and the audit will be repeated in November 2019.

Excellent multidisciplinary collaboration and teamwork was very evident to the assessors.

LDPH is a member of The Australasian Rehabilitation Outcomes Centre (AROC). De-identified data is submitted to AROC for each rehabilitation episode, and an extensive feedback document is provided with benchmarking against the Australian figures. The data for January to December 2018 identified that the patients at LDPH have an average age of 80.3 years, compared with the Australian facilities average of 74.4 years, and at LDPH 87% had at least one co-morbidity, compared with the Australian facilities average of 49%. Assessors were informed that this contributed to LDPH having an increased length of stay for their patients.

Developing the comprehensive care plan

Action 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.9	
Patients are supported to document clear advance care plans	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Risk screening commences at pre-admission, and screening and clinical assessments are documented. Part of the risk screening process is to ensure that patients do not have a requirement for extensive medical assistance, as this cannot be provided at the hospital.

Processes for shared decision-making include weekly case conferencing, multidisciplinary huddle, access to support services.

Venous Thromboembolism (VTE) documentation audit of the notes for 50 patients in August 2019 showed that even though the form was in all records, information recorded in patient notes, contraindications completed, and assessment completed were below an acceptable level, with the compliance being lower than the May 2019 audit. Due to the poor compliance with documentation in the current VTE assessment form, an action plan has been prepared which includes launching the new Healthscope Comprehensive Care Plan which includes VTE risk assessment.

A discharge plan is commenced at admission. Regarding the continuum of care, discharge information for practitioners taking over care is provided by medical, nursing and allied health staff, with the pharmacist reconciling every discharge list of medications. The multidisciplinary team also works with the patient and carer to determine their needs post-discharge.

Patients/consumers are aware of the clinician accountable for their care, as it is documented on the whiteboard in their room.

Patient allergies or other alerts such as mobility issues, falls risk are identified pre-admission and these are recorded on the alert sheet on admission. This includes the provision of an Advance Care Directive which is recorded on the alert sheet and then filed directly behind for ease of access. This information is also stored electronically in the WebPAS.

Patients are asked on admission if they identify as Aboriginal or Torres Strait Islanders.

Delivering comprehensive care

Action 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The current Ward Care Plan with multiple assessments is commenced on admission and is prepared by the admitting nurse, the patient and their carer, if nominated and consented to do so. Once completed and signed the care plan is placed in the end of bed medical record and is accessible by the multidisciplinary treatment team at point of care.

The care plan is available at the bedside handover along with the ISOBAR (identify–situation–observations–background–agreed plan–read back) handover form for discussion between the off shift and the oncoming nurse with the patient and their carer, if nominated and present at the time of hand over.

LDPH does not directly admit Palliative Care Patients other than DVA eligible persons. However, if a patient becomes palliative during their admission, they are referred to physicians experienced in palliative care.

LDPH participated in the National Stroke Audit in 2018. While there were some parameters which were met, there is room for improvement in others.

Due to complaints that patients see large numbers of different physiotherapists, there was an improvement made to the system. For a patient, this resulted in them seeing an average of three different therapists instead of six therapists, and as a result there has been a reduction in complaints.

All patients are asked during the admission process if they have an advanced care directive, and these are filed in the medical record.

Weekly case conferences with all team members discuss individual needs and discharge planning.

Minimising patient harm

Action 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Action 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Pressure injuries are managed well, with the rate of hospital acquired pressure injury stage 2 and above recorded as zero in the Healthscope Peer Group audit from January to March 2019, which is below the target peer group average. In addition, the rate of patients developing pressure injuries is below the industry rate and has been for the past five years.

LDPH falls rate was higher than the private industry rate (in 2018 0.43% compared to 0.31%) so there is room for improvement. In the Healthscope peer group falls resulting in fracture or closed head injury audit conducted January-March 2019, there were zero for LDPH. Although the ACHS clinical data trend for patient falls since 2015 has been trending up from 0.43% of bed days to 0.57% in 2017, it is pleasing to note the 2018 data indicates a trend down to 0.361% of bed days. The Allied Health team has a Stop Light system using coloured tape on mobility aids to act as visual cues to the patient and staff re the risk of falls to an individual. Fall prevention posters are in all the patient rooms.

"Call don't fall", posters are on display throughout the hospital to act as a visual cue for fall prevention and patients are provided with the brochure "Keeping a Step Ahead of Falls". A range of equipment is available.

The hospital caters for recognised diets and allergy needs, which are recorded on admission, and are accessible to the staff in the kitchen via the electronic patient information management system.

Mental health history is documented on the Alert Sheet.

LDPH provides all staff members with Workplace Aggression and Violence Education (WAVE). It is completed online and then reassigned on a triennial basis.

Prior to home visits a risk assessment is carried out.

Physical restraint is not used at LDPH, and chemical restraint only used on the advice of the VMO. All high-risk patients are transferred out to acute care with VMO approval.

Re Advisory AS18/14: The subjects of this advisory are Actions 5.7 and 5.10. LDPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Re Advisory AS18/15: The subject of this advisory is Action 5.13. LDPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Re Advisory AS18/04: The subjects of this advisory are Actions 5.8. LDPH has satisfied the requirements of this Advisory with a comprehensive action plan and ongoing monitoring.

Suggestions for Improvement:

It is suggested that there is an opportunity to address a recent audit result that minimal patients had no advance directive or treatment limiting orders documented in their medical record.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a comprehensive suite of Healthscope policies, procedures and guidelines governing clinical communication in addition to local LDPH policies and processes. Staff could demonstrate policy and procedure access at ward level. Assessors observed identity bands had the approved identifiers; however, the current practice to use red armbands for every patient regardless of their falls risk assessment is contrary to both Healthscope policy and best practice. Consequently, Action 6.2 is rated as Met with Recommendation.

Communicating for safety is a key aspect of the Healthscope wide "back to bedside" project which includes the A.I.D.E.T. communication technique, patient rounding and the focus on "always events" for both clinical and non-clinical staff. The 'always events' are behaviours that have focused staff on person centered care; the AIDET communication, patient rounding, bedside handover, patient care boards and acts of kindness have provided staff with a clear framework to communicate safely. The consumer is actively engaged because much of the communication happens at the bedside with the patient and family. Patient and carer related information, that is currently in hard copy, is safety focused. Plans are in place to make this information also available electronically through the patient information directory on patient TVs. This evidence-based information is designed to assist consumers in understanding the assessment and admission processes as well as facilitating an increased ability for the patient to participate in shared decision-making and goal setting. Results of regular audits indicate opportunities for staff to be more compliant with this patient-centered initiative, clearly favoured by many patients spoken with during the assessment.

Staff have access to education and training and regular updates related to communicating for safety. These include documentation, communication and review processes for identified risks. There is clear policy directive regarding consumer identification at both transition of care and high-risk situations, reinforced by guidelines, procedures and training.

Action 6.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Assessors observed an established practice of all admitted patients having a red arm band to signify a high risk of falls regardless of the result of the falls risk assessment. This practice is not compliant with Healthscope policy 2.08 nor best practice.
Recommendation:
Establish a process to ensure compliance with Healthscope Policy 2.08 Patient Identification Bands and regularly monitor and evaluate compliance.
Risk Rating:
Low
Risk Comment:
Compliance with policy and best practice is important for safe patient care.

Correct identification and procedure matching

Action 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope and LDPH policy, guidelines and procedures related to correct patient identification, procedure matching and approved identifiers and the processes are clearly articulated to the variety of settings. Assessors observed the use of three approved identifiers aligned to best practice guidelines during handover, medication management, the transition of care, at the commencement of therapy including procedures and interventions.

Non-compliance events are reported as incidents through RiskMan, reviewed and communicated through the governance committee and monitored at organisational and national level. Learning from incidents are managed, reviewed and shared throughout Healthscope including LDPH.

Communication at clinical handover

Action 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

During the assessment, multiple handovers and patient interactions were observed by the assessors where patients and families, where appropriate, were involved in goal setting, shared decision-making, care planning and assessment of progress using the ISOBAR format guided communication. Multidisciplinary handover meetings were observed to have a structured process to ensure comprehensive care and clear communication. Audits of handover documentation, care plans and bedside handover are regularly conducted and reported to the Patient Care Review Committee. Assessors noted variation in practice, that did not concur with the organisation's expectation for all clinical handovers between the afternoon and morning staff to include the patient at the bedside. The opportunity to review current practice in wards to ensure that patient engagement in bedside handover is not compromised was discussed with the executive during the assessment.

Suggestions for Improvement:

There is an opportunity to streamline bedside clinical handover between shifts to ensure that patient engagement in the bedside handover is not compromised by other procedures such as counting Scheduled Drugs and/or having a handover meeting prior to the bedside clinical handover.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Significant improvements have been implemented to support the quality and standardisation of clinical documentation. The use of Patient Care whiteboards located on the wall within the patient zone have been designed to highlight the days plan of care, to support involvement and patient communication with clinicians and shared decision-making at the bedside.

The daily multidisciplinary clinical team meeting at 9am is impressive. Similarly, weekly case conferences of the multidisciplinary clinical team including the VMO and other medical staff ensures clear communication between members of the team and the patient. Family conferences involving all members of the clinical team with the patient and relevant family members is positive.

Another impressive meeting occurs every morning where the Executive and all clinical and non-clinical managers meet to discuss the planned activities for the day including planned discharges and admissions, safety issues and planned maintenance on the day or within the week, such as loss of utilities that could impact on patient care.

Documentation of information

Action 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The documentation system and processes are supported by sound policies, procedures and guidelines that are evidence based and contemporary albeit a hard copy record. The few records reviewed contained critical information, alerts, and contemporaneous multidisciplinary documentation describing assessment, planning progress and outcomes. Changes in patient condition and risk were documented with appropriate escalation There is a formal system for entering new alerts into the record, governed by policy, with auditing and compliance overseen by the Patient Care Review Committee. The suggestion made in Standard 1 for a documentation audit process to be considered to assess and evaluate the appropriateness and effectiveness of the continuity of the patient care journey applies equally here.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are established systems and process for blood and blood product management in accordance with Healthscope and local policies. Oversight of blood administration is monitored, and any reactions or incidents are reported through the Patient Care Review Committee. Nevertheless, minutes provided to assessors had no documented reference to blood management. An identified need to strengthen the overall governance of blood management was discussed with the Executive team during the assessment.

Blood management risks identified on the risk register include the risks of administering incorrect blood and inadequate documentation in the medical record. Assessors note the current Quality Plan identifies the need to undertake an annual audit of compliance with documentation completeness. Blood safe training is provided to clinicians; training records indicate 93% n=105 of relevant staff have completed the required eLearning package. Processes are in place for reporting incidents and adverse events.

Consumers are involved in the identification of any potential risk/s they may have to blood transfusion leading up to the preparation for receiving blood. Special information sheets are provided to patients about receiving blood processes, possible risks and monitoring processes.

Suggestions for Improvement:

It is suggested that the clinical governance of blood management would be strengthened by including Blood Management as a standing agenda item on the Patient Care Review Committee.

Prescribing and clinical use of blood and blood products

Action 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

Protocols for prescribing and administering blood are in accordance with Australian and New Zealand Society of Blood Transfusion (ANZSBT) guidelines for the administration of blood products. Since 2016 the number of single pack transfusions has reduced from 65 to 51 in 2018. Year to date this decreasing trend has continued with 40 single packs transfused at time of assessment. Assessors were informed that the use of iron infusions has increased as an alternative prescription in accordance with the ANZSBT guidelines which is positive.

Audit results of ten (10) patient charts of compliance with required documentation of Healthscope HMR 10.8 chart identified that only three of the required fourteen items audited were rated as 100% complete. These included patient consent, date of blood prescription and legible prescription. The range of compliance of medical and nursing clinicians in this audit was 20% to 100% compliance, indicating a need for improvement. Improvement actions identified in the Quality Plan included education of medical and nursing staff. A repeat audit had not been undertaken at the time of the assessment but was scheduled for Q2 2019-2020. A Blood Transfusion Documentation checklist sticker for inclusion in the medical record has been introduced to heighten staff awareness and compliance with required documentation.

Suggestions for Improvement:

Given the very low volume of blood transfusions undertaken and the current low level of compliance with required documentation, consider completing an audit of all patient's medical records within a defined period of time, post the transfusion (for example less than 72 hours) to increase staff knowledge, understanding and significance of the requirement to document comprehensive information, including blood use, transfusion history and transfusion details, before, during and after transfusions.

It is also suggested that where possible have clinical staff from another clinical unit undertake the audit of medical record documentation related to blood transfusion to further increase knowledge and understanding of best practice.

Managing the availability and safety of blood and blood products

Action 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The storage, distribution and tracing of blood and blood products is governed and managed consistently with both Healthscope and local LDPH policies and protocols in consultation with the contracted pathology company. The blood fridge which is owned and managed by the contracted pathology company, is located in a storeroom within Peat Ward and is alarmed with an audible sound and regularly tested by a contracted maintenance company during programmed maintenance.

Assessors noted the incompleteness of the nTRA- Blood Fridge Maintenance Log during the assessment. Missing information included the fridge identification, month and the year of two record sheets located next to the blood fridge. Subsequently, the pathology company was notified and a RiskMan incident was generated. Assessors also noted incorrect documentation by a staff member receipting a patient's blood for transfusion two weeks prior to assessment period. Incorrect information included the wrong month and no year was recorded at all. Subsequently, a RiskMan incident was completed and the staff member counselled and required to undertake remedial education.

Blood and blood products are ordered and delivered into the blood fridge as requested for identified patients. The cold chain is actively controlled and locally monitored.

Blood wastage is managed by the pathology company and regularly reported to LDPH. Trend graphs developed by LDPH identify that there has been a significant decrease in blood wastage since 2017 which is impressive.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

LDPH complies with Healthscope policies related to clinical deterioration and has two additional local policies. The policies are reviewed and governed by the Quality and Risk Committee, the Clinical Working Party Committee, the Patient Care Review Committee and the Medical Advisory Committee.

The patient observation chart with track and trigger charting facilitates active management when a patient's physiological or psychological signs fall into the "call zone". If the patient reaches any of the trigger points nursing staff are empowered to call for immediate support including to NSW State Ambulance especially when there is no medical staff in the hospital. All Rapid Response Team and Code Blue (Code blue indicates a medical emergency such as cardiac or respiratory arrest) incidents are reported on the RiskMan system. Reports are tabled at the appropriate committees and plans are developed for the items that require action.

A mock code blue audit in April 2019 resulted in several recommendations. As a result of one of the recommendations, the Rapid Response and Medical emergency team policy and guidelines were reviewed by the Medical Director, Director of Nursing and the Staff Educator and modified accordingly.

Basic Life Support (BLS) training is completed by clinical and non-clinical staff. Clinical staff complete an online module and practical training annually, and non-clinical staff are given practical training annually; as of July 2019, BLS compliance with training was 98%.

New signage in the rooms includes instructions for patients and carers as to how to alert staff in the event of acute deterioration. These signs have been approved by the hospital consumer consultants. In addition to the signs, the hospital gives carers a brochure on escalation of care including patient, family and carer escalation of care, during the admission process to assist with education of patients, families and carers.

LDPH recorded 12 patients who have provided an Advanced Care Directive of all the Deterioration Classifications between July 2017- June 2019.

There is a plan to provide a defibrillator in the hydrotherapy area, together with a plan to educate staff on its use in this environment.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

An observation chart audit was conducted in December 2018 for 20 patients, with results of 100% for all items except for oxygen saturation which was documented for only 10 patients (50%). From August 2018, patient observations for sub-acute, long stay or palliative patients increased from once a day to twice a day, as a response to the observation that there were more patient acute deterioration episodes during the evening than during the daytime.

In addition to physical deterioration, mental deterioration is considered, and staff advised that there are psychiatrists available for consults if required.

If required, patients can have a relative to stay overnight if needed.

The Clinical Excellence Commission developed REACH Program - Recognise, Engage, Act, Call, Help is on the way, has been recently implemented in LDPH. The REACH program is to empower patients, carers and families about the processes for communicating concerns to clinicians. A brochure about the escalation of care 'REACH' is provided to patients on admission, and there is information about this on the walls in the patients' rooms. It clearly identifies the actions required for immediate assistance and gives advice about who to contact when the carer is concerned about the relative's condition but is currently not on site. Given the recency of implementation, it will be important to frequently review the effectiveness and performance of the system for family or carer escalation of care, to ensure appropriate action is taken to improve the system. Consequently, Action 8.6 is Met with Recommendation.

Staff have duress alarms at each nurses' station, in the consulting suite and at reception. Staff on home consultations go in pairs.

The RiskMan report 2017-2019, report on deteriorating patients identified, actions taken by staff, and where required, corrective action.

With respect to partnering with consumers in their own care, a RiskMan report June 2018-May 2019 noted that 94% of the 100 patients did not have advance directives or treatment limiting orders documented.

Suggestions for Improvement:

Consider relevant actions required to increase staff compliance with recording oxygen saturation on the general observation chart.

Action 8.6

The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

Recommendations from the previous survey were closed, and a new recommendation made because insufficient evidence was provided at assessment to demonstrate that the system for escalation of care was well established. The local policy in relation to family escalation was only written in weeks prior to the assessment. Whilst escalation of care had been audited from August 2016 to July 2019, there were nil escalations from family or carers recorded.

Recommendation:

Periodically review the effectiveness and performance of the system for family or carer escalation of care, and ensure appropriate action is taken to improve the system.

Risk Rating:

Low

Risk Comment:

Family escalation of care is an important aspect of safe patient care and can have a positive outcome for the patient.

Responding to acute deterioration

Action 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Clinical rostering ensures that the appropriate skill mix is included.

LDPH does not cater for acute medical patients and as such does not have the capacity to provide advanced life support (ALS) to be undertaken at LDPH. ALS is handled by NSW Ambulance Service on arrival at LDPH. Assessors were informed that the ambulance response time is approximately five minutes. Emergency trolleys are available in all wards with basic life support equipment available with an auto-diagnostic defibrillator on each trolley.

Recommendation from Current Assessment

Standard 1

Organisation: All facilities under membership
Action 1.27: The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Recommendation:
Undertake a gap-analysis of the current use of documented clinical guidelines, evidence-based clinical pathways, decision support tools and clinical care standards to identify opportunities for improvement, monitoring and regular evaluation of clinicians use of best available evidence.

Standard 4

Organisation: All facilities under membership
Action 4.10: The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result

Recommendation:
Establish a process to regularly review and evaluate full compliance with best practice required in the use of the National Standard Medication Chart (NSMC) and action identified areas for improvement.

Standard 6

Organisation: All facilities under membership
Action 6.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes

Recommendation:
Establish a process to ensure compliance with Healthscope Policy 2.08 Patient Identification Bands and regularly monitor and evaluate compliance.

Standard 8

Organisation: All facilities under membership
Action 8.6: The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

Recommendation:
Periodically review the effectiveness and performance of the system for family or carer escalation of care, and ensure appropriate action is taken to improve the system.

Rating Summary

Lady Davidson Private Hospital

Health Service Facility ID: 100984

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met
1.10	Met
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met
1.20	Met
1.21	Met
1.22	Met
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met with Recommendation
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met
4.2	Met
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met with Recommendation
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met
5.18	Met
5.19	Met
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Not Applicable

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met with Recommendation
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met with Recommendation
8.7	Met
8.8	Met
8.9	Met

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Standard 3

Organisation: Lady Davidson Private Hospital
Action 3.3: Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Recommendation NSQHSS Survey 0816.3.19.2
Patient infection prevention and control information be evaluated to determine if it meets the needs of the target audience.

Organisation Action:

- Consumer Representative has informally discussed the information provided to patients concerning Infection Control, subjectively the patients have answered in the positive related to instructions and advise.
- A structured survey will be conducted in February /March concerning the information provided on admission to patients within the formal information package.
- The survey will include specific questions concerning information /facility's provision on hand hygiene, wound care, surveillance of visitors with unwanted cold and flu symptoms, and what they want to know before admission to a rehabilitation hospital.
- Also, the survey will cover the requirements in relation to hydrotherapy treatments related to infection Control.

Completion Due By: 31.3.2019

Responsibility:

Organisation Completed: No

Assessor's Response:

Recomm. Closed: Yes

Patients and family members spoken with throughout the assessment confirmed their knowledge and understanding of the prevention and control information provided to them by Lady Davidson Private Hospital. Consequently, this recommendation is closed.

Standard 8

Organisation: Lady Davidson Private Hospital
Action 8.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Recommendation NSQHSS Survey 0816.9.9.3
Periodically review the effectiveness and performance of the system for family escalation of care.

Organisation Action:

- Consumer Representative has informally discussed the information provided to patients concerning Escalation of care, subjectively the patients have answered in the positive related to instructions and advice.

- A structured survey will be conducted in February /March concerning the information provided on admission to patients within the formal information package to ascertain if it meets the needs of patients at LDPH.
- Also, the survey will measure the awareness of the room signs that outline the Escalation of care available in the patients' rooms and if they understand the process.
- The survey will include specific questions concerning information /facility's provision on seeking urgent assistance from staff, the use and usefulness of the communication boards adjacent to all bed units and the nurse call system.
- Also, the survey if deemed suitable will include a question on Advance Life Directives to ascertain LDPH population's knowledge of this important care pathway available in consultation with their General Practitioner or their Visiting Medical Practitioner.
- Survey planned and development of an action plan to meet patient's expectation in the information and suitability of format provided.
- Yearly Audit conducted on Deteriorating Patient response undertaken by Director of Nursing.
- Rapid Response effectiveness has been evaluated within the Australian Hospital Setting - review of article circulated by the pertinent Clinical Cluster, effectiveness most evidenced in the over 80 age group - **ARTICLE:** Rapid response systems - Resuscitation magazine 121 (2017) 172–178 *State-wide reduction in in-hospital cardiac complications in association with the introduction of a national standard for recognising deteriorating patients* -Catherine Martina, Daryl Jonesa,b,*, Rory Wolfea a Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University, The Alfred Centre, 99 Commercial Road, Melbourne, VIC 3004, Australia b Intensive Care Unit, Austin Hospital, Studley Road Heidelberg, Victoria, 3084 Australia a r t i c l e i n f o

Completion Due By: 31.3.2019

Responsibility:

Organisation Completed: No

Assessor's Response:

Recomm. Closed: Yes

Insufficient evidence was provided to demonstrate that the system for escalation was well established. The local policy for family and carer escalation of care was written just weeks before assessment. Annual audits of escalation of care since the previous assessment did not record any family or carer escalation of care. Consequently, this recommendation is closed, and a new recommendation (Action 8.6) has been made to replace the two previous recommendations for family and carer escalation of care.

Organisation: Lady Davidson Private Hospital
Action 8.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Recommendation NSQHSS Survey 0816.9.9.4 :
Ensure that action is taken to improve the system for family escalation of care.

Organisation Action:

- Consumer Representative has informally discussed the information provided to patients concerning Escalation of care, subjectively the patients have answered in the positive related to instructions and advice.
- A structured survey will be conducted in February /March concerning the information provided on admission to patients within the formal information package to ascertain if it meets the needs of patients at LDPH.
- Also, the survey will measure the awareness of the room signs that outline the Escalation of care available in the patients' rooms and if they understand the process.
- The survey will include specific questions concerning information /facility's provision on seeking urgent assistance from staff, the use and usefulness of the communication boards adjacent to all bed units and the nurse call system.
- Also, the survey if deemed suitable will include a question on Advance Life Directives to ascertain LDPH population's knowledge of this important care pathway available in consultation with their General Practitioner or their Visiting Medical Practitioner.
- Survey planned and development of an action plan to meet patient's expectation in the information and suitability of format provided.
- Yearly Audit conducted on Deteriorating Patient response undertaken by Director of Nursing.
- Rapid Response effectiveness has been evaluated within the Australian Hospital Setting - review of article circulated by the pertinent Clinical Cluster, effectiveness most evidenced in the over 80 age group - **ARTICLE:** Rapid response systems - Resuscitation magazine 121 (2017) 172–178 *State-wide reduction in in-hospital cardiac complications in association with the introduction of a national standard for recognising deteriorating patients* -Catherine Martina, Daryl Jonesa,b,*, Rory Wolfea a Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University, The Alfred Centre, 99 Commercial Road, Melbourne, VIC 3004, Australia b Intensive Care Unit, Austin Hospital, Studley Road Heidelberg, Victoria, 3084 Australia a r t i c l e i n f o

Completion Due By: 31.3.2019

Responsibility:

Organisation Completed: No

Assessor's Response:

Recomm. Closed: Yes

Insufficient evidence was provided to demonstrate that the system for escalation was well established. The local policy for family and carer escalation of care was written just weeks before assessment. Annual audits of escalation of care since the previous assessment did not record any family or carer escalation of care. Consequently, this recommendation is closed, and a new recommendation (Action 8.6) has been made to replace the two previous recommendations for family and carer escalation of care.