NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Knox Private Hospital

Wantirna, VIC

Organisation Code: 221485
Health Service Facility ID: 101077
Assessment Date: 15/10/2019 to 18/10/2019

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

Knox Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 15/10/2019 to 18/10/2019. The NS2 OWA required 3 assessors for a period of 4 day(s). Knox Private Hospital is a Private organisation. Knox Private Hospital was last assessed between 10th - 13th October 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
Knox Private Hospital	101077

General Discussion

Knox Private Hospital (KPH) is one of the largest private healthcare providers in Victoria, and one of 43 hospitals in the Healthscope Group. KPH provides a comprehensive range of healthcare to the people in Melbourne's east and south-eastern suburbs.

KPH is a 359 patient-bed facility and provides a large range of medical and acute services including; 10 theatres, a 24-hour Emergency Department, an on-site medical team, a 10-bed Intensive Care Unit, a 10-bed Coronary Care Unit, a Day Procedure Unit, and a Hospital in the Home (HITH) service. KPH provides a comprehensive range of medical and surgical specialties including, cardiology, cardiac and general surgery, gynaecology, neurosurgery, orthopaedics, urology, plastics and vascular surgery.

At the time of the assessment, KPH had a reduced capacity of 244 beds due to the extensive building program which is currently taking place. The organisation had also experienced significant changes in senior and executive staff in the past year.

Regardless of the many changes taking place KPH presented as a very cohesive and supportive team clearly focused on ensuring the safety of their patients and consumers, and the continuous improvement of the high quality of care provided.

The assessment team was impressed with the level of multidisciplinary collaboration and partnership that is evident across KPH. This reflects the commitment by the executive and staff to engage consumers and the workforce in all aspects of the organisation.

The organisation has continued to improve its systems since the last assessment and there was clear evidence that staff are committed to improving care and services. Data is well used to drive ongoing improvement and the organisation benchmarks well against peers. Patients were very positive about the care they received and patient experience surveys support this view.

All KPH inpatient wards, units and departments were visited including Hospital in the Home (HITH). Non-clinical areas were also visited. The assessment team met with the Executive, a consumer representative, Visiting Medical Officers (VMOs), managers, clinical and support staff, patients and carers.

The organisation clearly demonstrated to the assessment team an ongoing commitment to patient safety and quality improvement. All NSQHS Standards (Second Edition) were assessed and were observed to have been Met. No recommendations were generated. Appropriate action has been taken as a result of the recommendations from the previous NSQHS Standards (1st Edition) survey. All previous recommendations were reviewed, and all were able to be closed with no further requirements.

The organisation is recommended for full accreditation.

Summary of Results

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

Knox 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.

Knox Private Hospital

Sites for Assessment

Sites for Assessment - Knox Private Hospital

Knox Private Hospital HSF ID:101077	
Address: 262 Mountain Highway WANTIRNA VIC 3152	Visited: Yes

Knox 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:

Knox Private Hospital (KPH) is part of the Healthscope Group which is governed by the Healthscope Board. In line with the Healthscope Strategic Plan, KPH has a Strategic Plan that sets priorities and provides the direction into the future. The strategic plan has undergone consultation with the consumers and is referred to when business and quality planning is proposed and undertaken.

There is a Clinical Governance Framework in place with clear governance and reporting lines delineated for all levels of staff from the Executive to the staff delivering the services. KPH has a comprehensive committee structure lead by the Executive Management Team which reports through to Healthscope as the parent body. KPH organisational safety and quality performance is monitored regularly through Quality Key Performance Indicators (KPIs) which are then reported quarterly to Healthscope (HSP).

KPH provides leadership for two HSP national committees, these being National Practice and Policy Committee and the Theatre Committee.

KPH is implementing the HSP Aboriginal and Torres Strait Islander (ATSI) Action Plan, which was approved by Reconciliation Australia in May 2019, at the local level. The KPH Community Action plan also includes strategies for engaging with Aboriginal and Torres Strait Islander communities. KPH has engaged with the Mullum Mullum Community Centre to further improve the understanding of the health needs of Aboriginal and Torres Strait Islander peoples. The KPH executive participates in the HSP Reconciliation Working Group. All patients are asked if they wish to identify as Aboriginal and/or Torres Strait Islander and the response data is monitored.

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:

KPH is governed by HSP policies and procedures as well as those which are developed locally. Clinical policies and procedures are readily available at the point of care through HSP Intranet (HINT) to inform clinical processes and a suite of policies are in place to inform other corporate processes. Systems are in place to ensure policies and procedures are contemporary, based on best practice, and are compliant with legislative and jurisdictional requirements.

Quality improvement strategies are documented in the KPH Quality Action Plan which was sighted by the assessment team. A comprehensive schedule of audits is in place and outcomes are reported through the Quality KPI reports. Quality action plans are generated in response to opportunities for improvement and these are monitored by the Quality Committee and at ward or department level.

The HSP Risk Management and Integrated Risk Register policy and procedure is in place at KPH. The Risk Register is a living document that is subject to regular ongoing reviews and is used as a management tool at relevant governance committees. As per the requirements of Fact Sheet 14, two high-risk scenarios were reviewed using the assessment framework for safety and quality systems (PICMoRS). The risks selected were 1) Safety and Security of Paediatric Patients in an Adult Environment, and 2) Management of Paediatric Resuscitation. The assessment team was satisfied that these risks were well managed.

The HSP incident management system policies and procedures are used by KPH. Incidents are monitored and managed via RiskMan. Incidents, near misses, complaints and sentinel events are analysed through the quality KPIs which are reported quarterly. Education and training is provided to enable all staff to report incidents and RiskMan is easily accessible to staff. Alerts to relevant staff are in place depending on the type of incident with relevant senior staff alerted to the incidents. Analysis of data is undertaken, and action plans initiated where areas for improvement have been identified. Over 90% of all clinical staff identified have undertaken the mandated eLearning for Open Disclosure and examples of appropriate open disclosure events were verified by the assessment team.

The recently established Patient Experience Manager position is integral to the feedback and Complaints Management systems at KPH. Feedback is gathered through daily manager rounding, from hard copy feedback cards available at all reception desks, and via email surveys from patients following discharge. The assessment team observed wards and departments viewing patient feedback in real time via the Patient Experience Portal (Qualtrics) and identifying opportunities for improvement.

KPH has a well-established complaints management system which is monitored by the Quality Committee through the quarterly quality KPI reports. The feedback module of the RiskMan system is used to document and track the management of complaints which are responded to in a timely manner. The complaints management process was observed to encourage accountability by initiating responses to complaints at manager and team level.

KPH has identified ethnically diverse and high-risk groups of patients. Risk assessments are conducted to mitigate the risks for consumers with special needs. Patient information brochures were observed to be available in many languages across KPH.

KPH medical records are readily available for clinicians at the point of care. Medical records not in use are securely stored on site with a secondary storage facility available off site. Secure processes for retrieval of medical records are in place. Medical record audits are conducted annually. A significant 2-year project was undertaken between 2017 and 2019, to improve the standard of clinical documentation with a Clinical Documentation Specialist, providing education to all clinicians.

KPH has developed an action plan to meet the requirements of Advisory 18/11. The KPH WebPas system links to the MyHealthcare Record (MyHR) and copies of discharge summaries are uploaded for each patient that has a MyHR.

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	All facilities under membership

Met with Recommendations	
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:

KPH was able to demonstrate that it has effective orientation programs for its leadership group as well as front-line staff in terms of their responsibilities and roles regarding safety, quality and clinical governance, with an appropriate range of topics. Attendance records are kept for orientation events. This is supported by resources including the Healthscope orientation policy and a structured corporate orientation program. This program includes requirements for nursing students, agency staff, volunteers, contractors and tenants. There is an orientation checklist for agency staff. There is also a 2-3-day supernumerary period in clinical areas. Self-directed learning packages for a number of safety and quality risks are included in orientation requirements. Visiting medical officer's responsibility for safety and quality are defined in the By-Laws and recorded in the credentialing system.

There was evidence that the organisation provides appropriate and effective ongoing education in safety, quality and clinical governance, in accordance with the Healthscope Mandatory Training and Education and Training policies. An education and training register in ELMO documents attendance at mandatory training sessions on a rolling 12-month program. Mandatory training requirements are periodically reviewed. Recent inclusions have been updated training for end-of-life care, cognitive impairment, bedside clinical handover and Aboriginal and Torres Strait Islander cultural awareness. Nurse educators provide opportunistic education as well as formal education sessions. Other regular education is provided by VMOs in sessions like the Friday Lunch 'n Learn, and the Emergency Department (ED) clinical lectures. Clinical simulation sessions in ED have enhanced team communication, and the Royal Children's Hospital PIPER training day at KPH focussed on deterioration in the paediatric patient. There is a mature undergraduate nursing preceptor model of education which is highly regarded and recently nominated for a Healthscope Star Award. Feedback from staff re the effectiveness of education was frequently sought and this provided the basis for future improvements. Evaluation of the orientation program and mandatory training are reported to the Education Committee.

There are a number of strategies to improve the awareness of the workforce to meet the cultural needs of Aboriginal and Torres Strait Islander patients, with clear evidence of uptake by staff. These strategies include “asking the question” ELMO training for administrative staff, and the “share our pride” video. An Aboriginal Elder recently gave a heartfelt “welcome to country” to a large gathering of KPH managers and staff.

The Healthscope performance review and development policy requires staff to participate in review of their performance, and the performance development process at KPH. This is monitored using the Oracle system, with reminders sent to ensure compliance. Performance review identifies specific training needs and identifies skill gaps, as does the national shared learnings initiative. Healthscope human resources department is available to support complex performance issues. Each nursing educator undertakes a training needs analysis in their respective department and develops a calendar of appropriate development activities, like online training, simulation sessions and the Lunch ‘n Learn sessions. VMO performance is reviewed and monitored by the Executive in a variety of settings like clinical review meetings, medical craft meetings and Medical Advisory Committee (MAC) meetings. Any concerns regarding performance are escalated according to the requirements of the By-Laws.

There is a structured process for the credentialing of medical, nursing, pharmacy and allied health clinicians as well as laser and radiation safety clinicians. Defining and monitoring their associated scope of practice is in place, within a well-defined policy framework, guidelines and governance structure the assessment team saw chemotherapy delivered by an appropriately qualified and credentialled nurse from Healthscope hospital in Ringwood who was cross credentialed for a patient requiring chemotherapy in Miller Ward. Credentialling of medical staff, including recredentialling for innovative technologies, is outlined in the By-Laws, and undertaken by MAC. Scope of practice of Visiting Medical Officers is available hospital-wide via WebPAS and this is a valuable tool for nursing staff. Regular auditing of compliance with VMO credentialing and scope of practice via the cGov system is undertaken, results of which are reported to Healthscope nationally. The assessment team noted the efforts of the MAC to delineate conditional privileges of some visiting medical officers as the result of serious incident investigation. The assessment team also noted that the requirements outlined in Advisory 18/12 for colonoscopist credentialing were met.

The organisation’s performance development policy outlines safety and quality roles for all managers and clinicians. The executive presents a reflection arising from a patient story in all of the peak committees. Consumers participate in safety and quality training at orientation. Position descriptions of all clinicians define responsibilities for safety and quality, as do the By-Laws for the VMO contracted staff. There was evidence of appropriate supervision of the clinical workforce, particularly graduate nurses, and ED registrars, and the ICU fellows to ensure that they are able to provide safe, high quality care. Overnight medical registrars and fellows are supervised by on-call specialists.

The health service supports the clinical workforce to provide safe, high-quality care with the provision of a range of best available evidence including guidelines, care pathways, screening and assessment tools, decision support tools and clinical care standards from the Australian Commission on Safety and Quality in Health Care (ACSQHC). All these tools are accessible via HINT. Clinical standards are distributed to medical staff by MAC, Theatre Advisory Committee, the relevant craft groups and clinical review meetings. The KPH sepsis pathway has been recently implemented at KPH and is being adopted by Healthscope nationally.

The assessment team noted the considerable efforts undertaken to implement the clinical care standards, including gap analyses, risk assessments, action plans, monitoring and reporting tools. Monitoring of the ACSQHC hospital acquired complications has demonstrated improvements better than peer hospitals in 2019, and the data is reported to the Healthscope Executive Board.

As part of a system to reduce variation in clinical practice, there was evidence that processes of care and health outcomes are regularly reviewed and that these are compared to performance data from other Healthscope facilities, as well as Safer Care Victoria and selected clinical quality registries, like Victorian Audit of Surgical Mortality (VASM), National Approved Provider System (NAPS), Australian Orthopaedic Association (AOA) joint registries and Australian and New Zealand Intensive Care Society (ANZICS) adult. Mechanisms exist to detect, investigate and act on unwarranted clinical variation within the health service, and to record risks of clinical variation both within the risk management system and in the credentialing systems for individual clinicians.

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:

The current extensive building program necessitated the relocation of the paediatric ward to be co-located within an adult environment. KPH has been diligent in risk managing this change and ensuring the safety of the adolescent and paediatric patients. A 'Management of Paediatric Safety Action Plan' is in place and progress is being closely monitored. Extensive education has been provided to all clinical and support staff, policies and procedures have been revised to reflect the changed environment and paediatric equipment has been updated. An information brochure has been developed for parents who are required to be with their child at all times. Parents of adolescent and paediatric patients interviewed by the assessment team, were very complementary regarding the clinical care, safety measures and support received.

KPH has a well organised and monitored schedule of maintenance and servicing for buildings, utilities, and equipment including medical devices.

Criteria are in place to recognise and respond to unpredictable behaviours with code grey and black strategies in place. De-escalation training has been provided for staff and security measures are in place. KPH was one of 4 Healthscope Hospitals included in the Occupational Violence and Aggression Hazard Report prepared in September 2017. Recommendations from the report were seen to have been implemented including installation of extensive CCTV in high risk areas of the hospital. Code Grey (alerts all staff to potentially or actively combative persons) and Code Black (Bomb Threat) incidents are reported through RiskMan and are monitored by the Quality Committee. The layout of KPH provides for easy access to calm and quiet environments.

Signage is clear and has been updated as changes have been made to the physical environment during the building works. A way finding terminal is located in the main entrance. A project is underway to create pocket size cards for consumers and visitors to assist in finding their way around KPH.

Flexible visiting arrangements are in place for patients to meet their needs. There is provision for family and carers to sleep and spend the night in hospital.

KPH has begun to address the need to create a more welcoming and culturally sensitive environment for ATSI people who attend the hospital. Acknowledgement of the Wurrundjeri Peoples of the Kulin nation appears on the patient TV channel and on the staff tele-information screen. Aboriginal and Torres Strait Islander flags are displayed at the main reception desks and Aboriginal artwork appears in the main entrance. In 2019 KPH recognised both NAIDOC week and National Reconciliation Week. KPH has also engaged with the Mullum Mullum Community Centre to enable referrals for support for Aboriginal and Torres Strait Islander people.

Suggestions for Improvement:

Continue to monitor the progress of the Management of Paediatric Safety Action Plan and ensure compliance with all safety and security measures implemented to minimise risk to paediatric patients.

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:

It was evident to the assessment team that consumers are at the heart of the service KPH provides and for them, and the inclusion of them in all aspects of their care is commended. Evidence was presented clearly demonstrating consumer involvement in the governance structure, and in the development and quality improvement of the service, displaying consistent and strong alignment with the Partnering with Consumer's Standard.

Knox Private Hospital (KPH) complies with Healthscope's Partnering with Consumers plan and has developed a Quality and Safety Plan and Consumer Engagement Plan with a Consumer Engagement Working Party to guide its partnership with consumers. The Consumer Engagement Plan is a working document and KPH has thought outside the box in advertising for consumer involvement in the hospital, resulting in the recruitment of 10 new consumer consultants who, following orientation and training will assist the hospital in providing consumer input across its committees and quality and safety areas.

Consumer involvement in the governance structure and in the development and quality improvements of the service is clearly evidenced in their involvement in service measurement and evaluation. The Quality Committee receives detailed regular reports pertaining to service provision and areas of issue or complaint through written reports and organisation member's feedback.

It is evident that the clinical governance standard and safety and quality systems are used when implementing policies/procedures and identifying training needs. Exemplars include monitoring compliance with policies related to safety and quality systems and involvement of consumers in evaluation and decision-making on safety and quality matters in the Quality Committee. Partnership in care with consumers is audited on across the episode of care, on admission, during clinical handover, and on discharge. The results of documentation and observational audits are reported through the committee structure, and the quality improvement system is used to demonstrate improvements that are fed back to staff and the governing body.

Risk mitigation for patients and consumers is managed through the risk register, and incidents involving patients, carers and consumers are managed through the incident reporting system RiskMan and reviewed by the Quality Committee. Staff are trained in person and family-centred care and other training is developed through performance management, education request, identification of needs based on incident reporting, or changes in practice.

Feedback from consumer satisfaction surveys, forums and discussions with all levels of consumers throughout the assessment were positive, with specific reference made to how well the organisation responds to feedback from surveyed consumers.

Suggestions for Improvement:

Involvement of the Consumer Consultants in service measurement and evaluation could be further achieved through their undertaking more patient feedback surveys on the ward to gain instant information and enable a quick resolution should there be any issues.

The use of electronic screens to explain services is a good way forward leaving walls uncluttered and all but the most important notices on display. This is an area that has the potential for further expansion in displaying achievements, community feedback results and also community education on topical issues such as immunisation and falls prevention.

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:

A lot of work has gone into how and when KPH partners with consumers in the provision of their health care. The Back to the Bedside (B2B) is a great example of this and has increased consumer participation exponentially. There is a high level of engagement of consumers at KPH. At the patient bedside, a strong connectivity between the patients and staff was observed that is typically demonstrated in small rural communities rather than larger urban hospitals, a very positive outcome.

As part of the B2B project five key areas were identified that patients said had most impact on their care, these 5 key behaviours have become “always events” for staff in their dealings with patients. That these strategies are working and appreciated by consumers is clearly demonstrated through consumer feedback and consumer satisfaction ratings which demonstrated a 26.5 % increase in 12 months.

KPH uses the National Charter of Patient’s Rights and Responsibilities, and this was observed displayed in public areas. A list of rights and responsibilities as stated in the Charter is included in the patient booklet and a patient safety video presentation, and the assessors verified with patients their knowledge of its whereabouts. The assessment team also found evidence of appropriate information being disseminated to patients related to their episode of care.

There is a mandatory approach to consent for treatments and procedures taking place within the hospital with consent clearly documented. Compliance with the informed consent process is monitored, reported and improved through education and resource development. Cognition is assessed on admission, and in the case of impairment, a substitute decision maker is sought who is a carer or family member. There are processes and resources to seek a public advocate if needed. Advance Care Directives are discussed with patients and families where appropriate. Patients are supported in preparing these directives if they so wish and patient that have directives have these noted in the clinical records.

KPH uses Healthscope policies and procedures and mandatory education ensuring staff are cognisant of the methods and conversations used to partner with patients in their care. Goal-based care plans and clinical pathways are used to encourage true partnership, and a consumer representative has taken part in the patient surveys that seeks feedback from inpatients about the partnering experience.

The KPH patient cohort is generally aged and not all want to be or are able to be actively involved in their care. Perhaps an unwillingness to participate should be documented on surveys and not form part of a negative result.

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:

The community served by KPH is very much English speaking with very little diversity affecting communication, however cue cards in three languages are available with a translation service available via telephone; an AUSLAN interpreter is also available for the hearing impaired. Staff read text to those who are sight impaired, and several areas have provided communication boards, printed standard questions with spaces to consumers to write their reply for the hard of hearing, a good initiative.

KPH utilises Healthscope consumer approved publications where available, with locally produced publications reviewed by the consumer consultants to ensure appropriateness of language, print and design.

KPH follows the Healthscope Reconciliation document, and a smoking ceremony was held and art work installed at its inauguration. Very few Aboriginal or Torres Strait Islander people use the health service, and the experience of long-standing staff is that they have been able to provide a good service with the resources available should someone identify as Aboriginal. Information Pamphlets for high risk areas for Aboriginal people are available.

All locally designed patient information is developed, reviewed and assessed with consumers and approved by the Consumer Consultant Working Party for legibility, relevance and ease of understanding. In view of the way in which consumers are involved and the way their input influences final documents the assessment team was pleased to see their input be acknowledged. A staff member trained in Health Literacy is involved in the development of local resources with other clinicians and/or relevant staff and consumers. Bedside audits and patient experience surveys seek feedback about information they receive, and the results are monitored and reported through the committee structure.

The community and consumers are kept informed on the organisation's quality and safety performance through the KPH website and the annual report.

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:

Evidence in both the Quality Committee and Executive committee minutes, verify that consumers are involved in consumer engagement strategies including building skills and capacity to engage with consumers, policy development and risk management related to consumer engagement.

Establishing and maintaining a Consumer Consultant Working Party is a successful means of involving the community in the identification and development of a consumer-focused health service and is to be commended.

The Quality Committee with its Consumer consultant representative receives all the quality and safety reports and is involved in discussion and decision-making about action that will be taken to improve quality and safety. A Consumer Consultant was an active member of the group designing and developing the new hospital areas currently under construction.

The diversity of the local population is reflected in the range of skills, employment and healthcare experiences of the recently recruited consumer consultants in an attempt to use a diverse range of skills and experiences to provide a broader community feedback. All consumers involved in partnership with the organisation are fully orientated and educated to understand their role as a consumer in partnership with the organisation, and their education needs are met in accordance with expanded roles. Consumer consultants have formal job descriptions including roles and responsibilities for Quality and Safety.

KPH catchment area has a very low Aboriginal population, however contacts have been made with a local Public Health Aboriginal Health Service and with the Knox Council to create engagement in the area. Contact has also been made with Maroonda Public Hospital Aboriginal Liaison Officer to further links in this area to provide support for patients identifying as Aboriginal.

Consumers are involved in the patient information video which is played across the hospital. Staff are very conversant with the video and the patient experiences depicted. Patient journeys and stories are also utilised in staff orientation and education.

Patient surveys, local and state-wide, and other information gathering exercises are undertaken to identify areas for improvement within the organisation. Feedback was identified as positive and it was pleasing to see that this information was shared during ward handover meetings.

Suggestions for Improvement:

Consumers have been used in staff education in the past but this is an area that could be usefully expanded through the use of scenarios, role play and videos to good effect for both staff and patients. Looking at using technology in the form of videoed patient journeys and patient feedback could be successful given that face-to-face places stringent time constraints on both consumers and staff. These may be in-house or online from other organisations.

The community and consumers are kept informed on the organisation's quality and safety performance through electronic visual displays in the hospital, and it is suggested that these be augmented with educational snapshots of issues relevant to the community.

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:

The Infection Prevention and Control system across Knox Private Hospital (KPH) is effectively supported by the multidisciplinary Infection Prevention and Control Committee (IPCC), which is chaired by the Executive Director of Nursing (DoN). The KPH Infection Prevention and Control system is also supported through the Healthscope contract with Healthcare Infection Control Management Resources Pty Ltd (HICMR).

Infection control risks and outcomes are recorded in RiskMan, monitored by the IPCC and are reported through the Senior Leadership Team to the KPH Executive Meeting. Infection prevention and control is a standing item on the KPH Quality Meeting agenda which is attended by the Infection Control Co-ordinator (ICC).

Policies and procedures are in place which meet legislative and jurisdictional requirements and are available to staff both electronically and in hard copy. There is an Infection Control Risk Management Plan in place which reflects the requirements of the NSQHS Standards and is updated annually.

Audits are conducted, in accordance with the infection control clinical auditing schedule, to monitor compliance with policies and procedures including hand hygiene, aseptic technique, standard and transmission-based precautions, and management of invasive devices.

KPH participates in national, jurisdictional and peer benchmarking surveillance activities through, for example, Victorian Nosocomial Surveillance System (VICNISS) and the Australian Council on Healthcare Standards (ACHS) Clinical Indicator Program. The assessment team observed a consistent and comprehensive infection prevention program in place and were able to verify a range of successful improvement activities across the organisation. The infection control audit activities are reflected in the organisation wide clinical audit schedule which ensures integration of all clinical monitoring strategies.

A diverse range of consumer reviewed and endorsed infection prevention and control literature has been developed to assist patients and visitors to understand infection control risks and responsibilities. The information ranges from the disease or organism specific to the requirement for prophylactic antibiotics. The consumer information is also readily available on the KPH web page, in pre-admission clinics and at the point of care, and is also used when managing outbreaks to ensure that all patients and families have best practice information.

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:

Standard and transmission-based precautions, consistent with national guidelines, were observed to be in use across KPH. Standardised signage for transmission-based precautions was seen by the assessment team, as was appropriate Personal & Protective Equipment (PPE) relevant to the precautions required. Monitoring of compliance with standard and transmission-based precautions occurs in line with the IPC audit schedule and is reported at the IPCC.

KPH has achieved a hand hygiene (HH) result of 88% across the organisation, which is above the national benchmark of 80%. There are 3 HH Gold Auditors and an additional 23 members of staff have been trained as auditors. The assessment team observed variation in HH performance between some clinical units and noticed some craft groups are performing less well than others. All employed and contracted members of staff are required to undertake online learning for HH. There are hand hygiene stands and posters in public areas, and alcohol-based hand rub (ABHR) is available to the public and is located in all clinical areas and in each patient, room close to the patient. A segment on HH on the Patient TV channel encourages consumers to ask clinicians if they have performed HH.

An organisational risk analysis of aseptic technique (AT) was been undertaken. High-risk clinical areas and clinicians have been identified as have the aseptic technique competencies. A mandatory online training package is available to all clinicians and has been completed by 98% of all KPH nurses. A program is in place to assess theory and the clinical practice of AT for clinicians annually. Compliance audits are conducted with Visiting Medical Officers (VMOs) for AT compliance. An annual Invasive medical devices audit is conducted in all clinical units and departments and compliance is reported to the IPCC.

The assessment team was impressed with the standard of environmental cleaning, observed in all clinical and non-clinical areas, across KPH. An audit schedule is in place with results monitored by the IPCC. Legionella testing and risk mitigation is in place and as is annual High Efficiency Particulate Air (HEPA) Filtration testing.

There is an employee immunisation program that complies with national guidelines and jurisdictional policies. Staff immunisation information is collected prior to commencement and is reviewed by the ICC and the HICMR Consultant. Evidence was sighted by the assessment team demonstrating good compliance of staff with completed immunisation in high-risk clinical areas.

An annual influenza vaccination program is in place and is being actively progressed, delivered by employed team of nurse immunisers, with participation rates reported to the IPCC, executive groups, and the Quality Committee. KPH Health has improved on the 2018 participation rate with an overall rate of 70% as at the time of assessment.

There are evidence-based policies and procedures for the prevention and management of occupational exposures available for all members of employed and contracted staff. Compliance audits are conducted which include the use of Personal Protective Equipment (PPE) and the safe use and disposal of sharps. Occupational exposure incidents are reported through RiskMan and are monitored by the IPCC.

Infectious risk assessments are conducted in the Emergency Department (ED), on admission to the ward or unit, and during the patient's stay in hospital. All patients with infections are flagged on the electronic patient administration system. The patient's infectious status is communicated during clinical handover, and whenever responsibility for care is transferred within or between departments or facilities.

Suggestions for Improvement:

The assessment team suggests that the organisation continues to work to minimise the variation of HH performance across all areas, where clinical units and craft groups are performing less well than others.

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 a formal training program conducted by HICMR, that is consistent with industry standards, for all staff involved in the reprocessing of reusable medical devices, with competency assessments conducted regularly. At the time of assessment, it was noted that 87% of the Central Sterilising & Supply Department (CSSD) staff had completed all units and assessments.

Reprocessing of Trans Oesophageal Echo (TOE) probes is conducted in the Cardiology Heart Centre using the Tristel System by accredited staff who undertake annual education. HICMR conducts an annual audit of reprocessing compliance.

The requirements of AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations and the Australian Commission on Safety and Quality in Health Care's Advisory (ACSQHC) A18/07 are well understood. The assessment team sighted the Gap Analysis conducted by HICMR which included progress reports demonstrating significant progress.

KPH has demonstrated satisfactory progress towards full implementation of their plan for AS/NZS 4187:2014 and meets the requirements set out in Advisory AS18/07 (version 2 August 2019). Progress is regularly monitored by the IPCC and the Executive Committee.

There is an effective tracking system in place for scopes and reusable medical instruments back to the individual patient. All instrument cleaning and sterilisation equipment is regularly serviced, and appropriate monitoring is in place. Cleaning service audits are conducted regularly and monitored by the IPCCC.

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:

KPH antimicrobial stewardship program is evidence based and includes the components from the Antimicrobial Stewardship Clinical Care Standard. The assessors verified that a well-structured governance framework is in place for strategy implementation, monitoring and reporting. Improvements in compliance with guidelines and appropriate dosing for antimicrobial medications are reported to the Infection Control Antimicrobial Stewardship Subcommittee (AMS). This committee reports to the Infection Control Committee and Senior Leadership Team meetings. Surgical prophylaxis reports are also furnished to the Theatre Advisory Committee, Anaesthetic Advisory Committee and MAC. The physicians Medical Review Committee has nominated undertaking an audit of antibiotic usage for their inaugural meeting.

AMS monitors prescribing, antibiotic resistance and identifies areas requiring improvement. Verification confirmed that KPH has developed an AMS formulary, policy on restricted antibiotics, referral, approval and review of antimicrobials. Compliance with the various AMS programs is high. KPH also has a consumer awareness program with prominent posters strategically placed in public areas. “The more we use antibiotics, the more we lose antibiotics” and “No action today, no cure tomorrow” campaigns were notable. The pharmacy department uses a Restricted Antimicrobial Sticker on the medication chart as a forcing function for approval by infectious diseases physicians. Restricted antibiotics must be re-prescribed after 48 hours. The pharmacy department also provides patient brochures regarding appropriate antibiotic use, and clinical pharmacists educate patients on discharge.

Antibiograms are provided monthly by the IPC Nurse and results are both valued and discussed by prescribers. Hospital National Antimicrobial Prescribing Survey (NAPS) and National Antimicrobial Utilisation Surveillance (NAUSP) have been completed with feedback to medical staff. Victorian Healthcare Associated Infection Surveillance System (VICNISS) Surgical prophylaxis pathways, approved by the Pharmacy Committee and MAC, are available on all anaesthetic trolleys, and there is good compliance demonstrated across surgical disciplines. Surgical prophylaxis reports for hip and knee arthroplasty and coronary artery bypass patients are submitted quarterly to VICNISS.

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:

Medication management is integrated into the KPH governance systems, is supported by a strong framework, including the Healthscope medication safety governance policy. There are two contracts supporting medication supply functions at KPH, namely the HPS Pharmacy which delivers Clinical Pharmacy services and supplies all non-imprest stock and the CH2 contract for imprest supplies. The multidisciplinary Pharmacy Committee reports to the peak Quality Committee. There is a suggestion regarding expanding the Terms of Reference of this Committee in line with Healthscope medication safety governance policy, which includes requirements for Methicillin-susceptible Staphylococcus aureus (MSSA), quality use of medicines indicators, TallMan lettering, high risk medication management and user applied labelling requirements.

Policies and procedures support standardised medication management across the organisation. Policy direction is provided by Healthscope and there are some clinical guidelines developed locally. All had been reviewed recently, with the contact persons and author and review dates documented. Compliance with policies is audited regularly and fed back to the services. The assessment team found consistency in understanding of and compliance with key aspects of medication policy across the organisation. For example, MAC has led improvements in the signing of telephone orders within 24 hours so that compliance is satisfactory.

Medication management audits are part of the Healthscope-wide schedule, and include Healthscope KPIs, the Medication Safety Self-Assessment, and the National Standard Medication Chart Audit as well as High Risk Medications and S8 audit. A number of medication related risks are mitigated and monitored on the Risk Register. Medication-related incidents and adverse drug reactions are reported, reviewed and acted upon. The most serious incidents are reported and monitored at MAC, Quality Committee, Pharmacy Committee and Clinical Review Committee meeting.

Bedside handover incorporating medication management was seen to occur, and nurses and clinical pharmacists actively engaged with patients, providing information in a manner which met the patient's needs. At discharge, a medication profile is produced by the Clinical Pharmacists to provide a both a medication list and range of key information at discharge.

Scope of practice relating to management of medications is well-defined and regularly reviewed. Credentialing occurs for medical staff, pharmacists and enrolled nurses. Graduate or inexperienced nurses and pharmacists are supervised and mentored appropriately. Nurses complete a range of mandatory medication safety modules, including drug calculation and paediatric dosing calculations, as well as instructions for a best possible medication history and use of the medication chart.

Suggestions for Improvement:

It is suggested that the Terms of Reference of the Pharmacy Committee are expanded to incorporate the requirements of the Healthscope medication safety governance policy, including the Core Characteristics 8 and 9 of the MSSA.

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:

A Best Possible Medication History is gained by checking at least two sources of information regarding medications on admission. High risk patients are identified where there are 4 positive parameters on the comprehensive risk screen form. These patients are referred to the ward-based clinical pharmacist for a medication management plan and medication review. Appropriate medication reconciliation occurs at transfers of care. Clinical pharmacists produce a medication profile for all discharge patients, which is discussed with the patient. Supplemental information includes the CMI, and brochures like the antibiotic administration brochure. Medication review activities by the clinical pharmacists is highly valued and is documented in the monthly report to the Executive.

There are processes for documenting a patient's history of allergies and adverse reactions relating to medicines, and also to food, latex, adhesives, and other substances. These checks occur at patient presentation, are repeated throughout the admission, including prior to medication administration, and appear well embedded. There is a system to notify Pharmacy of suspected adverse reactions, an assessment of causation and severity of this reaction and, if appropriate, reactions are added to the Alert screen on webPAS and reported to the Therapeutic Goods Administration. Reactions associated with anaesthesia are forwarded to the Anaesthetics Advisory Committee for consideration. Red identification bands are used for patients with allergy or adverse drug reaction (ADR), consistent with policy.

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	All facilities under membership
Met with Recommendations	
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:

Clinical pharmacists are consulted to perform a medication review on any patient with 4 positive parameters on the comprehensive risk screening tool. These reviews include a prescription review, patient compliance issues review, and opportunities for rationalising medications. Medication reviews are undertaken in partnership with patients. Education for patients is provided by the clinical pharmacists, supplemented by tools like the Consumer Medicines Information (CMI), brochures (for example the antibiotic brochure). These assist information exchange in a format easily understood by patients. A medication profile which lists all the medications is produced by the clinical pharmacist for all discharges and at any transfer of care.

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:

There is good access to decision support tools for clinicians. The latest version of MIMs and the Australian Injectable Drug Handbook are available in each clinical area as well as the Australian Medical Handbook (Paediatrics) and Royal Children's Hospital (RCH) Injectable guidelines in the Paediatric area. There are numerous medication information services available on HINT.

Medication rooms, pharmacies, medication cupboards and trolleys were secured across the organisation, and there have been recent efforts to improve the storage of imprest drugs in wire baskets. High-risk drugs according to the APINCHs acronym were well understood, with laminated posters in each medication room. A local initiative has reduced distractions in the medication room in Kenloch Ward by way of a laminated red sign "Do not enter, Count in progress". A red dot system is used to flag any expiring stock on resuscitation trolleys. The assessment team was provided details of progress against an action plan to further improve the storage and labelling of the imprest supplies. Controlled drugs are stored and accounted for in accordance with Victorian requirements and S8 and S11 Register audits are regular.

ANZCA guidelines from 2018 for the safe storage of anaesthetic agents highlight that drugs used in anaesthesia may be the target for diversion or abuse. Secure storage and access precautions assist to mitigate misdirection of these drugs.

There is a suggestion to review the storage of anaesthetic medications with the potential for drug addiction, like Propofol.

The assessment team noted the results of the recent MSSA and as noted above, there is a suggestion to regularly monitor improvements against the MSSA at the Pharmacy Committee, particularly in Core Characteristics 8 and 9 in accordance with Healthscope medication safety governance policy. There is the opportunity for the Pharmacy Committee to regularly review drug utilisation and wastage so that the imprest supplies are optimised.

There is good understanding of cold-chain management. Medication-grade refrigerators, which alarm locally, are widely available and daily monitoring is conducted. The assessment team noted that the vaccine-grade refrigerator is located in the supply area. There is a suggestion that its location be reviewed. In order to ensure cold chain management when any department is unattended, there is a suggestion that maximum/minimum temperature ranges of these refrigerators are checked first thing in the morning if departments are not staffed 24/7.

Return to Pharmacy containers in medication rooms provide a receptacle for unused, unwanted or expired medications. The HPS Pharmacy manages the recycling of and disposal of medications. The assessment team noted that there is a current improvement project in the collection schedule for unused, expired or unwanted medications from all wards.

High-risk medicines are managed through an integrated system of policy, guidelines, forms, audits, education and tools. High-risk medications are listed on the risk register, and high-risk medication incidents are monitored. Line labelling and syringe labelling remains an improvement project for the hospital. Storage of Potassium ampoules is limited to ICU and is appropriate.

Suggestions for Improvement:

It is suggested that the Pharmacy Committee regularly review drug utilisation and wastage reports so that the medication room inventory levels are optimised.

It is suggested that KPH review the storage of anaesthetic medications with the potential for drug addiction, like Propofol

It is suggested that maximum/minimum temperature ranges of medicine-grade and vaccine-grade refrigerators are checked first thing in the morning if departments are not staffed 24/7 to ensure cold chain management when the department is unattended.

It is suggested that KPH reviews the location of the vaccine-grade refrigerator.

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:

The Healthscope Clinical Governance framework facilitates and guides Knox Private Hospital (KPH) staff to ensure appropriate monitoring systems are in place to deliver comprehensive multidisciplinary care. A comprehensive suite of Healthscope Policies are in place to guide staff in their care and in the development of appropriate and designated local Policy, Procedures and Guidelines. There are relevant and appropriate governance systems implemented to support clinicians to deliver comprehensive care which is congruent with evidenced practice across KPH. Relevant remedial plans are instigated in response to anomalies identified.

KPH Committees are structured with definitive lines of reporting and delegated responsibilities to ensure governance oversight of the quality improvement program across the organisation. The Quality Committee articulates a reporting schedule together with the necessity of the provision of action plans in response to where areas for improvement have been noted. This committee has a reporting function to the Senior Leadership Team and Executive.

The Director of Nursing's bed meetings, led by the NUMs are utilised to review hospital capacity, workloads, staffing, giving a clear picture of the organisation's workload, capacity and efficiency. This has resulted in greater efficiency, reduced patient and staff stress and increased patient care outcomes. It has also seen an increase of discharges before the 10am stipulated time by 30%, this together with the reopening of the discharge lounge should further improve capacity.

A comprehensive audit program is in place re to ensure monitoring of clinical practice against evidenced based policies, procedures and guidelines occurs. The audit schedule forms part of the quality improvement program and reporting structures are in place to ensure that actions are implemented in response to deficiencies identified. Feedback on performance is provided to relevant committees and working parties with information flows back to frontline clinicians.

Risks are identified via a variety of assessment tools with strategies implemented to mitigate risks. There are both strategic and operational risks identified for comprehensive care and are located on the Risk Management Program. Mitigation strategies are clearly articulated and there is clear indication that risks are reviewed at the highest level of governance. Overall compliance for risk assessment and management for KPH is 92%.

Staff educational needs are identified and appropriate education and training is implemented to ensure staff are well versed with expectations and ways in which comprehensive care is expected to be delivered. Patients' needs and levels of risk are identified via the risk screening and assessment tools available to and used by staff. A range of data is collected from the screening assessment and is used to monitor performance and augment quality improvement activity. Key performance indicators and clinical indicators data are also obtained via RiskMan, clinical audits, non-clinical audits, mortality and morbidity meetings to measure a range of services provided and benchmarked between services, and against peer hospitals. Outcomes are tabled at all levels of governance across KPH and the Healthscope organisation. Reporting is in line with the schedule articulated by governance structures. Quality improvement activities are captured via a Quality Improvement Register which acts as the repository with individual areas also retaining their own quality improvement registers and evidence of improvements.

Feedback is obtained from patients and clients on a regular based in a variety of ways and used to improve the delivery of comprehensive care. This has included the review and revision of models of care to ensure optimal patient centred care is provided and aligned with evidenced based practices. Examples where consumers are encouraged to set goals in a collaborative manner with healthcare workers is reflected in the comprehensive care plans and the use of Patient Centred Bedside Boards and in the End-of-Life model of care. Goals are reviewed and updated daily in consultation with the client, and family where appropriate, and is instrumental in individualising care and ensuring clients' end-of-life wishes/needs are met.

Comprehensive care is provided utilising a risk management approach and ensuring appropriate action is taken in response to areas of concern. Staff commitment to providing safe and reliable care is evidenced by the proactive and innovative approaches noted in the delivery of comprehensive care across KPH.

The Back to the Bedside (B2B) project has energised staff, promoted teamwork and together with the new comprehensive risk assessments and care plans, bedside handover, multidisciplinary meetings, manager and hourly rounding's has increased the comprehensive care experienced by patients, reduced risks and improved outcomes. Patient's feedback, in all its forms, validates all the staffs' hard work.

Patient care is also being improved through the use of shared learning's across Healthscope, involvement in research projects such as the Falls Screening Processes Research which has resulted in the development and implementation of a comprehensive screening tool linked to a comprehensive care plan, and QI projects undertaken by staff in all areas of the hospital.

Suggestions for Improvement:

Day surgery Venous thromboembolism (VTE) audit demonstrated a 90% compliance rate, but also identified that the screening tool did not differentiate between paediatric patients and adults, this is an area that could usefully be reviewed to ensure more accurate auditing.

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:

Policies and processes ensure that a comprehensive clinical, cognitive and social assessment is undertaken at admission. Further assessment is undertaken within specified timeframes of the policy with audits demonstrating a high compliance. Admission documentation across all services includes risk triggers to identify need of in-depth assessment for all areas of risk identified.

On admission, a paper based comprehensive screening is undertaken on all patients using validated assessment tools which are ongoing through the episode of care. Physical, cognitive, social and cultural history, issues and risks are identified and documented. From this a comprehensive multidisciplinary care plan is developed utilising initial admission documentation, clinical notes from the treating doctor and allied health staff with input from the patient and family to identify patient goals. The introduction of the 4AT screening tool is a good step towards identifying delirium early ensuring appropriate care can be provided, follow up audits will demonstrate its effectiveness.

Information relating to patient condition, risks, outcome goals and any immediate social issues are discussed both at handover and team meetings. Currently, the care plan is updated by nursing staff from ongoing assessments and clinical notes made by Allied Health and Medical Practitioners.

Referral to required services is made on admission or following further assessment during or following the admission process. Referral for ongoing treatment and care was clearly demonstrated during clinical handover and in-patient review meetings and huddles further re-enforcing the care panning. Staff recognise that the care plan is about the patient not just the condition, and this has been clearly demonstrated in the identification of both long and short-term patient goals which are documented in the care plan and the patient bedside boards.

Policies and procedures are in place with admission documentation documents requiring the identification of Aboriginal and Torres Strait islander people should they so wish. Education for front line staff using the video “How to ask the question” has been undertaken with 87% of staff trained in asking the question and recording in clinical admission data. Cultural education for all staff utilising the video “Share our pride” has been undertaken with 83% of staff completing the training.

Currently, the numbers of patients admitted with a completed Advanced Care Plan are low, however staff has knowledge on how to initiate this discussion with patients and families, giving information and referrals on Social Workers available to assist patients and families in decision-making.

The use of track and trigger documentation clearly identifies patient deterioration with policy and procedures in place to guide staff in the processes for escalation of care, providing clear steps and reducing risk. Patients and families are informed of processes they can take should they be concerned about their care or condition.” Let me know Posters” in each patient area provide prompts and contacts for this process. While recently implemented there have been few escalations of care initiated by patients and carers. This may be due to the newness of the process or to the other strategies of Hourly Rounding and Manager Rounding which may have negated the need for some escalations. Further review by patients and family will ensure its appropriateness and usefulness.

As part of the comprehensive care planning, discharge planning begins at admission and provides information to the patient to ensure continuity of care. The reopening of the discharge lounge has provided a comfortable place for patients to await pick up and allows for better care planning and bed management.

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 comprehensive multidisciplinary care plan is maintained in the patient notes at the bedside and used by all care givers to provide care, assess ongoing needs and identify ongoing treatment and care for the patient. The care plan is completed in consultation with the patient and family as appropriate, with the patient identifying a daily goal which is documented here and on the patient care bedside board, ensuring participation in planning and provision of care.

Specific care, treatments, diets, examinations and tests and patient goals, are noted on the patient whiteboard ensuring all staff attending the patient are aware of their needs and identify patient and family involvement in the care process. Clear symbols on the care board clearly identify patients requiring extra assistance and attention is a good initiative to highlight vulnerable patients.

"Let me KNOW" a rapid response for escalation of patient care and concerns is established across the organisation with notices in all ward areas, patient rooms and at the bedsides, and in-patient information, giving instruction on how to facilitate this. Staff are trained in explaining the process and responding to any patient escalation of care.

During the assessment, assessors attended the ward handover meeting prior to bedside handover taking place. There was a good team feel, cooperative and focused with engagement from all staff. All areas of patient feedback were discussed and areas for improvement identified. Feedback from staff on patients of concern was also a focus ensuring the whole team were aware of any issues.

The establishment of hourly rounding and manager rounding has seen a drop-in falls risk, complaints and enabled on the spot resolution of concerns. Multidisciplinary weekly meetings occur where patients are reviewed for care effectiveness, change in care needs and finalisation of discharge planning care.

Policies, procedures, tools and documentation consistent with the National Consensus Statement are available to assist in the identification and care for patients at end of life. KPH staff providing palliative care utilise the “Last days of Life Care” manual providing staff with support and strategies for identifying, managing and supporting both the patient and the family. This manual, together with role modelling has led to greatly improved recognition of palliative care patient entering this stage of their life ensuring improved care and support. The regional Palliative Care team provide specialist advice, review acute clients and support through visits or via teleconference or telephone. Staff are trained to discuss end-of-life care with patients and family to enable shared care decisions to be made, supported by information packages and specialist clinical information.

KPH has system of codes to assist staff in dealing with identified risks to the patient, others or themselves; these are broadcast over an intercom system to provide information and support for those needing it. Warning posters have also been developed to clearly identify patients at risk of displaying aggression or violence for staff.

Suggestions for Improvement:

During assessment, patients indicated that they thought the white bed boards were for the nursing staff rather than for them. Given this is a new initiative further promotion on their use and function may be needed.

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	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Preventing pressure injuries

Evidence-based policies and procedures, screening and assessment tools are utilised to support staff in the prevention and care of persons at risk of, or with a pressure injury.

Given KPH cohort of patients there is an excellent record with pressure injuries. All assessments, care plans and equipment are in place and used effectively. While a large proportion of the KPH patients are in the older age groupings, the acute admissions are also aging and more vulnerable to pressure injury and it is good to see that risk assessments are carried out on all admissions. The effective use of the multidisciplinary team to assist and advice in this area of care is providing appropriate patient care, and the nursing workforce have completed training for pressure injury prevention and management.

KPH has a wound clinic and Clinical Nurse consultant who is available to assist staff in their assessment of and management of pressure injury and wound care. Compliance with wound care management guidelines is high.

All admissions are assessed for the risk of pressure injury utilising a modified Waterlow Scale with pressure relieving equipment and mattresses utilised. Further pressure reducing equipment is able to be sourced should this be necessary. The assessment tool is completed within eight hours of admission, at regular intervals according to identified risk, with daily skin or more frequent inspections undertaken for identified patients. The nutrition status of the patient is recognised as being important in the prevention and treatment of pressure injuries and is covered in the nursing admission risk assessment.

A care plan is commenced on admission with assessment levels being a 'standing item' during clinical handover. Care plans, processes and routines are well established, with the use of preventative equipment and skin care, with those at risk clearly identified on the patient journey board.

Pressure injuries are notified via RiskMan and it was noted that there while there had been no hospital acquired pressure injuries, patients admitted with a pressure injury were immediately identified on RiskMan, a patient-centred care plan developed and prompt treatment demonstrating that the strategies in place are effective.

Risk is reviewed throughout the episode of care, during surgery and treatments. Audits demonstrated excellent compliance with these tools and policies. Audit and KPI results seen by the assessment team clearly demonstrate that the strategies that have been put in place have resulted in improvement resulting in the extremely low rate of pressure injury.

A mattress audit is also undertaken annually to ensure their integrity. Active pressure relieving devices are also available. Pressure injury prevention equipment is identified on the organisation’s equipment register which is current and well managed with equipment immediate available. A maintenance schedule is identified, and equipment tagged.

The patient information booklet provided to all patients and families on admission gives information on preventing and managing pressure injuries. Patients and, where possible, carers, are involved in the assessment and subsequent development of care plans and proposed interventions. Verbal and written information is given throughout the episode of care and repeated as necessary.

Patients surveyed indicate that they were engaged in their treatment and provided appropriate information about their care.

Falls and harm from falls

KPH has good processes, assessments, care plans, equipment and a multidisciplinary team for the mitigation of falls and injury from falls which is evidenced through falls auditing and RiskMan reviews. The use of a dedicated falls promotion to highlight falls to both staff and the community is a good initiative.
The hospital has up-to-date policies and procedures that encompass falls prevention, screening and assessment with falls prevention and management well done across the hospital.

Falls risk is assessed on admission and monitored throughout the patient journey, with falls data reviewed and reported through the governance structure. Outcomes are reported and reviewed at ward level with action plans for improvement developed, implemented and monitored, at all levels of the organisation.

Evidence-based guidelines have been utilised to support staff in the prevention and care of persons at risk of a fall. Screening and assessment tools are used for all patient profiles and commence on admission. The system is well structured, comprehensive and accessible to staff. A wide range of equipment is available for staff members to use, to assist patients and to reduce the risk of a fall occurring.

Actions taken to reduce the falls risk include clear identification of patients at risk of falling at bedside handover, on bedside care boards and on the ward patient journey board along with their requirements of mobility aids. Data seen by the assessment team identified a continuing downward trend in both falls and harm from falls a positive result.

The “Preventing falls at Home” identified by Hospital in the Home (HITH) as a project to be developed in the near future would further improve patient safety.

Staff education on falls commences at orientation and continues with online sessions on prevention, dealing with falls and post-fall ensuring competency of staff. Falls champions and falls folders support ward staff in their prevention and management of falls. Should a fall occur processes are in place to activate an alert ensuring full assessment of the patient, staff discussion and assessment in a ward huddle, identification of mitigating strategies, reporting of the fall on RiskMan, and provide feedback to the patient, family and medical staff.

Patient and carers are provided information about falls prevention while in hospital and for discharge. Falls management discussions at discharge and any ongoing care referrals are documented in the clinical record. Patients surveyed indicate that they were engaged in their treatment and provided information about their care.

Nutrition

Healthscope policies guide KPH processes in the assessment of nutritional risk and management with nutritional assessment undertaken through the Comprehensive Risk Management tool on admission and at intervals throughout the episode of care should this be necessary. Identification of special needs occurs through the in-depth malnutrition screening E-MUST with referral to appropriate allied health staff and the provision of appropriate diets.

Allergies are identified and recorded in the clinical notes, care plan, patient journey board and bedside whiteboard. An electronic kitchen management system identifies food alerts and provides a tailored menu for allergies, dietary lifestyle and religious preferences.

KPH nutrition and hydration management procedure and food service menu provide operational support for staff optimising nutrition to promote wellbeing, recovery and the prevention of malnutrition through appropriate consumer reviewed and dietician approved menus. Episodes of malnutrition are monitored, with assessment data identifying a downward trend in episodes to best practice levels.

Catering staff delivering the meals are made aware of any special needs of the patient through the patient whiteboard by each bed and ensure that all food is delivered to the correct patient, trays are within reach and assist with food opening should this be necessary.

Processes are in place to ensure uninterrupted mealtimes with the programming of non-essential investigations and tests outside of patient meal times.

Following feedback from patient, initiatives to improve patient enjoyment of food and reduce wastage, improve nutritional status and reduce the incidence of malnutrition, has included the move away from an all freeze cook process to a mix of freeze cook and fresh cook with a more varied diet including tasty salads which has been greatly appreciated by the patients.

Preventing delirium and managing cognitive impairment

The management of delirium is identified as one of KPH top risks with policy and procedure documents relating to delirium and cognitive impairment in place and adhered to. These make reference to screening, assessment, care and prevention strategies and are aligned to the Delirium Clinical Care standard. The system supporting delirium and cognition are monitored through RiskMan reports, incident analysis, clinical reviews and patient feedback and demonstrate good compliance.

Delirium and cognition screening and assessments occur on admission using validated tools including the 4AT, are recorded in the health record and continued throughout the episode of care should this be identified as necessary. Patients presenting to the Emergency Department with a fractured neck of femur are automatically flagged as a high risk of delirium and this is clearly identified in the patient's clinical notes with Clinical Instruction Role Assessment Tool (CIRAT) stickers.

Care planning is individualised and well documented. Family and carers are engaged in the development of care as required with information about delirium available.

The employment of Assistants in Nursing to support and assist cognitively impaired patients is a very good initiative as is the initiation of the diversion therapy box to assist in the reduction of stress and anxiety in this cohort of patients.

Predicting, preventing and managing self-harm and suicide

While KPH does not provide any mental health services, Healthscope Policy documents outline the processes by which persons at risk of self-harm or suicide are identified, managed and transferred to an appropriate facility. Screening for risks commences at point of entry into the service utilising the Comprehensive risk screening tool. If a positive screen is identified the pathway for referral, secondary assessment and ongoing care is articulated. Care planning is individualised, safety orientated and documented in the medical record, with referrals made to specialist mental health, or primary care services as required. KPH has focused on ensuring the environment is safe and reducing anxiety and distress.

While no incidents of self-harm have been recorded, monitoring of the system is via RiskMan reports, self-reported incidents, clinical reviews, mortality and morbidity meetings and patient feedback. Such incidents would be formally reviewed and recommendations made actioned.

Predicting, preventing and managing aggression and violence

Both Healthscope and KPH policies are in place to assist staff in the identification of and management of aggression and violence. The identification of potential aggressive and/or violent behaviours is identified during the admission assessment and throughout the episode of care using the comprehensive risk assessment form with information from family and carers used to identify potential triggers. Such risks and associated care plans are entered into the care plan and body of the clinical record. Patients identified at risk of becoming aggressive or violent can be specialled by members of the clinical work force or suitably skilled contracted security personnel in the short term with strategies in place for ongoing care or transfer to appropriate care facilities.

Risks of aggression and violence are minimised by reducing environmental and procedural triggers for aggression. Exemplars include the establishment of quiet rooms, adoption of sensory modulation techniques, and environmental segregation for vulnerable persons. The adoptions of Assistants in Nursing and diversion therapy boxes are good strategies in managing aggression and violence from the dementia and delirium cohorts of patients.

Challenging behaviour incidents are recorded in RiskMan but are few and challenging behaviour is not listed on the risk register.

Challenging behaviour eLearning WAVE 1 and Wave 2 training is undertaken across the organisation with high compliance. Should de-escalation actions not be successful a code alert is signalled with staff trained to respond. KPH has designed a sign that is posted on the door of wards where patients have a history of violence and abuse to clearly indicate this to all levels of staff with duress alarms available in outpatient offices and treatment areas.

Code Black is utilised for personal danger situations. For most sites the primary response is provided by security staff or the police. Security incident report review suggests few code Black calls due to staff training and environmental changes.

During the assessment, limited evidence was sited of carer and family feedback regarding their participation in the treatment planning for aggression and violence during the assessment of patient.

Minimising restrictive practices

Seclusion and restraint are not an endorsed practice in the KPH general health care setting. Physical restraint is utilised by trained staff only to enable the provision of therapeutic interventions under a treatment order or to prevent injury to the patient, others or staff. Chemical restraint requires a medical review and authorisation with ongoing assessment of the patient's condition.

Each episode is recorded and reported into the RiskMan System. The rates of the use of seclusion and restraint are low and are in accordance with policy directives.

Improvement initiatives across services have focused on minimising the use of restraint and seclusion and include enhanced communication skills, diversion practices and the creation of safe places for vulnerable persons.

Suggestions for Improvement:

The suggestion of a project investigating the implementation of the Safer Victoria "End PJ Paralysis (ENDPJP)" where patients are up out of bed for meals and dressed, is a good initiative in the prevention of pressure injuries and something that could be worthwhile to explore.

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	All facilities under membership
Met with Recommendations	
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:

Governance, policies, procedures and reporting are all well established locally and nationally. There is evidence at KPH of systems in place to ensure timely, effective communication that supports continuing, coordinated and safe patient care. These systems are supported by executive leadership and a culture of patient-centred care. Communication for patient safety is well embedded in the clinical governance framework and there is a maturing culture of patient participation in care with evidence that the patient is at the centre of care. There is evidence that systems and strategies are in place to ensure that communication for patient safety is integrated and is used to inform changes and future directions.

KPH has good relationships with its VMOs and GPs and this has been strengthened through Continuing Professional Development evenings for GPs. Evidence of these relationships were seen by the assessment team.

Strategies are in place across the organisation to clearly identify patients, communication of information both routine and critical for both patients and staff so ensuring continuity of care, sharing of information and patient safety including follow up phone calls following discharge following surgery.

The development of an innovative theatre list in day surgery for the identification and flow of patients through the unit including a patient belongings book and a dedicated handover nurse has streamlined the flow and reduces patient risk.

Examples of improvement in communication for patient safety were witnessed during the assessment. Once again, the Back to the Bedside Project, bedside handover, multidisciplinary meetings, manager and hourly rounding, huddles and the recent roll out of “Let me KNOW” escalation of care initiative have all increased safe communication for the patient. The partnering with consumers post-graduate project in the emergency department looking at how to better support and involve patient and family in an arrest situation is a good initiative with the potential for very positive outcomes.

Further improvements have been made to improve consent for surgery. Some forcing functions have been implemented by the elective surgery booking office and this is continually measured with improvements being noted.

Electronic patient journey boards are used to map the patient journey effectively. They were observed in staff-only areas thus mitigating against any privacy risks.

A review of a sample of hospital and community health records found clear, accurate, detailed records that assist both the provision of and transfer of care between clinicians.

There are systems in place to monitor effectiveness of communication for patient safety. This includes audits of patient records, patient surveys, complaints management and audit of clinical handover. These are reported via the Quality Committee to the Executive. The risk register includes matters relating to communication such as consumer feedback, clinical handover and discharge planning. There is no evidence of adverse outcomes relating to communication.

The Quality Action Plan reinforces teamwork to identify areas for improvement. It encourages patient participation in goal setting and other aspects of their care. Clinicians described good working relationships and communication with VMOs, Local GP practices and Ambulance teams with evidence seen during the assessment.

There is a determined intent to enable patients to be involved in communication of their goals of care during bedside handover. During survey the assessors observed this and patients were well prepared and had their questions ready for the clinicians.

There is an extensive range of information available to support and inform patients and families during their episode of care with some areas developing “Talking Cards” with routine questions in large print and on which the answer can be written to assist visually and hearing-impaired patients, a good initiative.

The development of a Transport access guide, with maps and information of all forms of transport enabling access to KPH; the Patient Finder, a guide assisting families and friends to track the status and location of a patient, together with the Find My Way board showing the way to all wards and departments located in the foyer, are all effective ways to communicate with patients, families and the wider community. The invaluable role of a Concierge at the hospital reception desk to ease patient and family anxiety and facilitate movement across the hospital is to be commended.

There is information and signage identifying a 10 am discharge time which has caused some anxiety for patients and families in the past, but the re-opening of the Discharge Lounge has reduced patient stress at discharge.

Suggestions for Improvement:

Opportunities exist for the implementation of further strategies to improve communication with carers and patients relating to the use of bedside whiteboards and the patient escalation of concerns.

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:

During the assessment many checkpoints confirm patient identification utilising approved identifiers were observed by the assessment team. Identity was checked at admission, bedside handover, any transfer to and from wards, on reception to and from theatre or clinical departments. All clinical staff attending the patient confirmed their identity, with non-clinical staff addressing patients by name. Time out and procedure matching in theatre and departments also included patient identification. Monitoring and reporting of ID matching is in place and there is no evidence of any adverse outcomes.

Patient flow and identification checking has been streamlined for day surgery through the use of an innovative theatre listing system and a dedicated handover nurse who checks the patient into the ward, transfers them to theatre and receives them back to the ward. A good initiative for patient safety.

Food service staff have procedures for patient identification at meal delivery including talking to the patient and checking the bedside whiteboard.

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:

The assessors attended both shift and transfer handovers in clinical areas as well as time out in theatre. The intent of handing over responsibility and accountability for care was evident.

There is a systematic approach to handover using the ISBAR (identify-situation-observations-background-agreed plan-read back) framework with evidence of bedside handover with patient participation. Bedside handover enables the staff and patient to reinforce goals of care and patient progress as well as discharge planning. Several clinical huddles were observed by the assessment team and these are key times critical to enhancing communication for patient's safety. Where observed, the patients seemed to really appreciate bedside handover and used it as an opportunity to ask questions. While a multidisciplinary handover was not observed during the assessment, a multidisciplinary meeting where all patients are discussed in relation to need, progress, future care and discharge planning occurs weekly.

Monitoring of clinical handover occurs with high compliance and this is reported up to the Quality Committee and Executive. There has been no negative feedback from patients about their participation in handover and no evidence of privacy breaches.

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:

KPH has recently introduced a system for communication of critical information by patients and family, "Let me KNOW". This allows the patients or family to escalate clinical concerns or questions about care. The procedure outlines a number of steps to escalate concerns and is displayed prominently across the hospital, in patient's rooms and in-patient information. While the intent of the system is well displayed, it is still in early evolution and patients spoken to identified they had not needed to use it. Staff also indicated they had not received any concerns or questions. For it to be effective more promotion may be required. There was no evidence provided to indicate that this system has been audited or evaluated at the present time.

The introduction of hourly rounding and Manager rounding are two good initiatives for patient safety and increasing communication and these may be the reason escalation of care communication has not been needed. Audits of all processes will identify their usefulness.

The use of track and trigger charts provide clear guidance for staff in identifying critical information for reporting, together with new information gathered from patients or family which impacts of patient care and safety. Processes are in place for staff to contact VMOs and GPs should this be necessary and clear lines of communication for escalating information within KPH are in place and known by staff. Critical information is also transferred during ward handover and huddles.

Suggestions for Improvement:

Strategies be identified to ensure all patients and families are aware of the escalation process and how to activate this.

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:

Policies and processes are in place guiding the documenting of patient information at KPH where a paper medical record document system is used. Regular medical record audits are conducted as per the audit schedule and demonstrate high compliance with all aspects of documentation and storage.

Patient's clinical notes are available to all clinicians at the bedside enclosed in drop down boxes for privacy and to provide a documenting area, again taking care back to the bedside.

Discharge summaries from both the emergency department and wards are faxed to GP surgeries with 98% sent within 48-hr of discharge.

Patient admissions and registration areas were visited with Medical Record Departments having restricted access. Systems are in place for secondary storage and archiving. Medical records are delivered to clinical areas as requested by trolley courier service which maintain privacy and accurate and speedy transfer. Good systems are in place to minimise risk of duplicate medical record numbers.

While some patient admission and risk information is available electronically through the whiteboards, there is no evidence of systems in place as yet for an electronic health record.

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:

The clinical governance and systems for blood and blood product prescribing and clinical use at Knox Private Hospital (KPH) are safe and appropriate. Regular audits are conducted and reviewed by the multidisciplinary Blood Management Working Party which reports through the Senior Leadership Team (SLT) to the Executive Management Team (EMT).

Blood and blood products are supplied when needed from onsite contracted providers, Australian Clinical Labs and Dorevitch Pathology.

All requests for packed cells are compliant with the relevant standards. The KPH Blood Transfusion and Blood Appropriateness audit results demonstrate that the indication for red blood cell transfusions are appropriate and follow the 'one unit then reassess principle' of Patient Blood Management Guidelines in the majority of cases. Iron infusions are prescribed to optimise haemoglobin levels where possible.

KPH has representation on the Healthscope Transfusion Cluster that reviews the latest evidenced based care and transfusion related forms and policies and procedures.

A comprehensive Blood and Blood Products Prescription and Transfusion Record form has been implemented since the last KPH survey to further mitigate risks associated with such procedures.

A major focus of the patient blood management program is to ensure patients are aware of the options, as well as risks and benefits of blood product transfusion. Explicit information related to blood transfusion appears on the Quality and Safety section of the KPH web site. Patients are provided with comprehensive information about having a blood transfusion and indicate on the consent form that they have received explanation of potential risks. Consent audits sighted at the time of assessment demonstrated compliance in 96% of patients.

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:

The most recent audit of prescribing and clinical use of blood and blood products, conducted in June 2019 showed that in 90% of cases the indication was documented, and treatment was consistent with the guidelines.

All clinicians involved in the transfusion process are supported to complete the mandatory BloodSafe eLearning modules and orderlies who transport the Blood products are also required to complete relevant modules. Mandatory training records sighted during the assessment demonstrated 100% compliance for clinicians and 96% for the orderlies.

There have been no adverse transfusion related events at KPH in the last five years. Processes for the management of adverse transfusion events are in place.

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:

Utilisation and wastage at KPH is monitored by the Blood Management Working Party. The education program for clinicians is comprehensive and is underpinned by mandatory blood eLearning programs. There has been minimal wastage of blood as a result of the supply chain coordination. There is a single Blood Refrigerator at KPH which is maintained by the contracted Pathology providers. There was evidence of excellent communication links and supply chain coordination for Massive Blood Transfusion. Simulation exercises for massive blood transfusions have been conducted this year in operating theatres and in the emergency department. These simulated events were very positively evaluated.

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:

There are various policies and procedures from Healthscope as well as local KPH policies to support recognition and response systems for the deteriorating patient. The policy is consistent with the National Consensus Statements for physical deterioration, high-quality end-of-life care and mental state deterioration as well as the Delerium Clinical Care Standard.

Quarterly KPI reports and incident reports regarding deterioration are tabled at the Quality meeting, MAC and relevant craft group meetings as well as reporting to Healthscope nationally. This promotes benchmarking of key quality indicators against peer hospitals. KPH Morbidity and Mortality meeting reviews all Metcall and Code Blue reports monthly against standardised criteria. This committee is multidisciplinary and has good medical representation. KPH participates in the Australian and New Zealand Intensive Care Society (ANZICS) Core Adult Patient database and reports other relevant clinical indicators such as rapid response attendance within 5 minutes, and unplanned ICU admission within 24 hours of procedure.

All patient incidents related to recognising and responding to deterioration are recorded, managed, investigated and analysed via the RiskMan System. In addition, there is a comprehensive audit schedule of the various observation charts, including Adult, Paediatric and Emergency Department track and trigger charts. A comprehensive review of a serious adverse incident in OR has led to system changes like hi-vis fluoro jackets for Code Blue team members, and Basic Life Support (BLS) training of Theatre technicians amongst other system improvements. There was evidence that Medical Emergency Team (MET) activations are systematically analysed using the MET audit tool. Mitigation of risks associated with deteriorating patients are noted on the risk register.

Risks for cognitive impairment are comprehensively assessed throughout the patient's journey including at pre-admission and on admission, in partnership with patients and carers. A medication management plan and medication reviews by the clinical pharmacist are undertaken in partnership with patients on psychotropic agents who are at risk of mental state deterioration.

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	All facilities under membership
Met with Recommendations	
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:

KPH uses track and trigger charts to record vital signs for adult, paediatric and emergency department patients. There is comprehensive training of clinicians in appropriate recognition and recording of acute physical deterioration, and appropriate calling for assistance in case of deterioration of physical parameters. All Metcalls and Codes are evaluated and reported to the Quality Committee.

In addition, documentation of deterioration in mental state is undertaken on the comprehensive risk assessment form (using CIRAT tools) and 4AT forms as well as the Behaviour Chart. Alerts are noted both on the Alert medical record form and the WebPAS system. In accordance with Advisory 19/01, KPH has rigorous processes to identify and respond to delirium. KPH is progressing the action plan resulting from the gap analysis, and the timelines on the action plan are due for completion by December 2019. A Psychiatric Liaison Nurse Practitioner has been appointed and there are processes for rapid consultation to mental health clinicians and referral to mental health facilities. Processes for partnering with consumers and carers where there is deterioration in mental state are well demonstrated. ICU is piloting a SaferCare Victoria initiative with a pain, agitation and delirium “PAD” score assisting recognition of mental state deterioration in intubated patients. There has been a notable improvement in the HAC11 indicator for delirium which is now better than peer hospitals.

Family escalation processes are being rolled out at KPH as a three-tiered approach outlined on the “worried about your loved one?” brochure. There have been no escalations to the third tier as yet; however, there are brochures, posters and the patient care board initiative as well as the patient TV channel to empower patients and their families in this regard.

There is a medical record alert form and WebPAS screens which reflect the agreed parameters and documented goals of care according to the “medical orders for life sustaining treatments” form and in addition, the “Comfort, Observation, Symptom Assessment” (COSA) form for palliative patients. These alerts enable clinicians throughout the organisation to view ceilings of care decisions generated in partnership with patients and there is a mechanism in place to update these documents when they are refined by clinicians and patients. A recent initiative “Back to Bedside” board in the staff station updates any changes to these ceilings of care daily.

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:

Mandatory training rates for Basic Life Support (BLS) training across the organisation are high and as a result of a serious incident, theatre technicians are now also BLS trained. Advanced Life Support (ALS) trained staff from CCU and ICU attend all Metcalls and Code Blue events across the hospital including in OR and ED, and paediatric trained staff from ED attend any paediatric deterioration. There are also appropriately skilled and trained responders for overnight events. Skilled responders are delineated for simultaneous Metcalls. Additional special training has been provided for KPH staff to cover various scenarios, like the RCH PIPER paediatric training, simulation training in ED, WAVE training for Code Grey events, and massive blood transfusion events. In addition, the ICU staff have undertaken specialty Cardiac Surgery Advanced Life Support (CALS) training for sternotomy patients. Resuscitation trolleys are standardised and checked daily.

Processes for transfer to higher level care for complex patients stabilised at KPH Private are in place. Such patient cohorts include most emergency paediatrics, stroke patients, clients requiring a mental health admission, patients requiring hyperbaric therapy, ICU patients requiring respiratory weaning and deteriorating cardiac surgical patients requiring extracorporeal membrane oxygenation (ECMO).

Recommendation from Current Assessment

Nil

Rating Summary

Knox Private Hospital

Health Service Facility ID: 101077

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
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
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	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
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
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 1

Organisation: Knox Private Hospital
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 NSQHSS Survey 1016.1.7.1 :
Review the format of clinical guidelines to ensure they indicate those involved in reviews and consultations and are appropriately referenced and authorised.

Organisation Action:

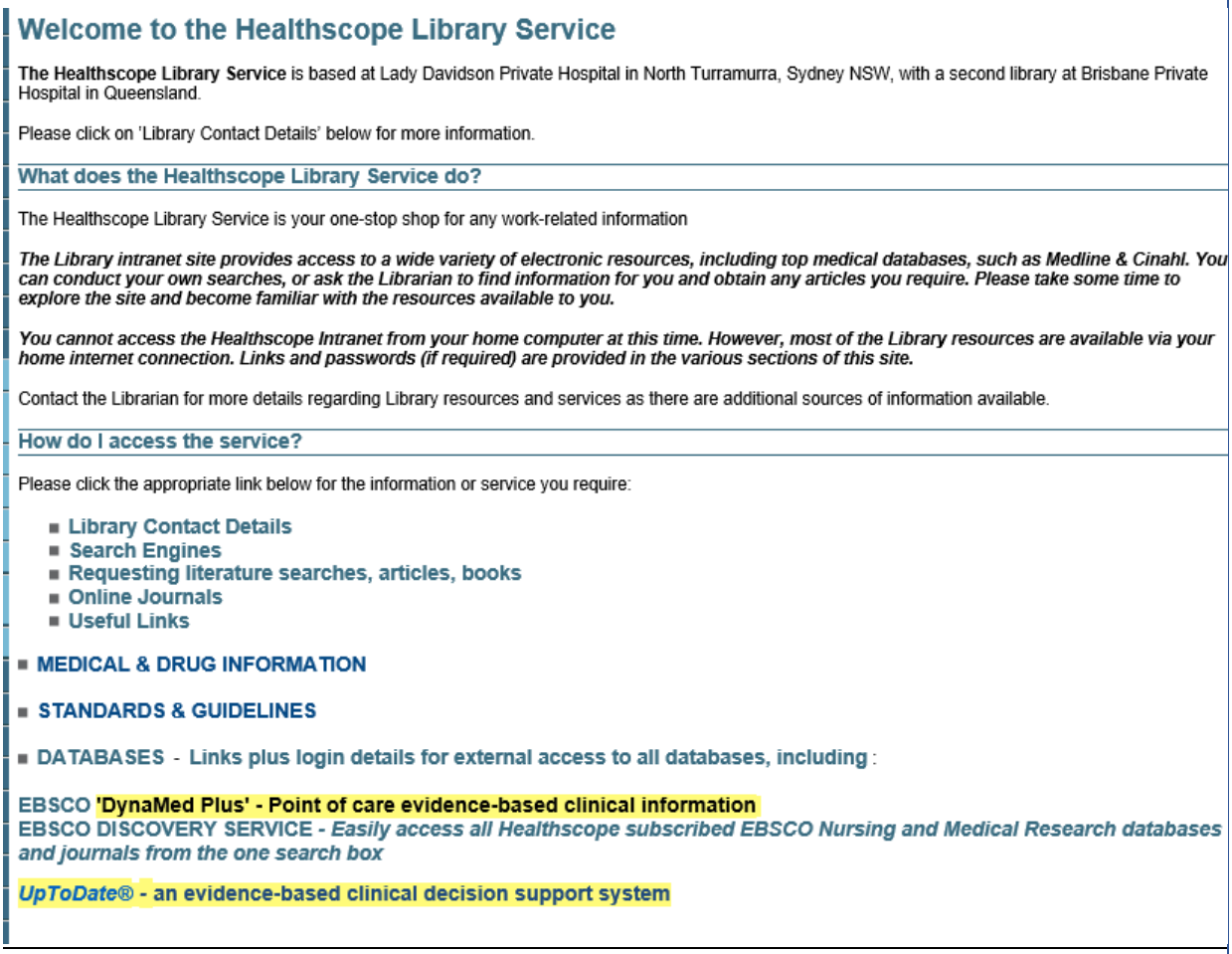
Clinical Guideline database established. Guidelines in the database are:

- listed by clinical speciality
- date
- next review date
- author
- comments
- distribution for review
  Database is maintained by the Quality Manager as per Document Controller policy.
  Clinical Guidelines initially developed in 2013.
  Clinical Guidelines: distributed to the Nurse Educators for review and reference documentation. Commenced 2017.

2018:
Educators: guidelines distributed and not completed as staff resigned with allocated portfolio for the review of clinical guidelines.
Cardiac Guidelines x 4 completed
Orthopaedic Guidelines x 2 completed

Clinical Guidelines currently allocated for review = 10

2019:
Clinical Guidelines for best practice available on Healthscope Intranet (HINT). The currently titled Knox Private Hospital 'Clinical Guidelines' are reflective of nursing practice plans and Visiting Medical Officers preference pathways.



Welcome to the Healthscope Library Service

The Healthscope Library Service is based at Lady Davidson Private Hospital in North Turramurra, Sydney NSW, with a second library at Brisbane Private Hospital in Queensland.

Please click on 'Library Contact Details' below for more information.

What does the Healthscope Library Service do?

The Healthscope Library Service is your one-stop shop for any work-related information

The Library intranet site provides access to a wide variety of electronic resources, including top medical databases, such as Medline & Cinahl. You can conduct your own searches, or ask the Librarian to find information for you and obtain any articles you require. Please take some time to explore the site and become familiar with the resources available to you.

You cannot access the Healthscope Intranet from your home computer at this time. However, most of the Library resources are available via your home internet connection. Links and passwords (if required) are provided in the various sections of this site.

Contact the Librarian for more details regarding Library resources and services as there are additional sources of information available.

How do I access the service?

Please click the appropriate link below for the information or service you require:

- Library Contact Details
- Search Engines
- Requesting literature searches, articles, books
- Online Journals
- Useful Links

- MEDICAL & DRUG INFORMATION
- STANDARDS & GUIDELINES
- DATABASES - Links plus login details for external access to all databases, including :

EBSCO **'DynaMed Plus' - Point of care evidence-based clinical information**
EBSCO DISCOVERY SERVICE - ***Easily access all Healthscope subscribed EBSCO Nursing and Medical Research databases and journals from the one search box***

UpToDate® **- an evidence-based clinical decision support system**

2019 June:
The Clinical Pathways have been renamed Nursing Practice Pathways.
The Maternity pathway (1) archived due to the closure of the Maternity Unit in January 2019.
Nursing Practice Pathways reformatted following discussion and agreement with Nurse Unit Managers and Nurse Educators.
File Name change on the L: public drive location for Nursing Practice Plans.

Knox PRIVATE HOSPITAL

Nursing Practice Plan

1.003 Coronary Artery Bypass CABGS) or Valve repair/replacement

DAY OF ADMISSION/PRE-OP	Day of Surgery & Day 1 Post Op in ICU DAY 2
Full patient assessment	Daily weigh before breakfast
Baseline vital signs and vascular obs – then 4 hourly	Full patient assessment per shift or if patient condition changes
Complete patient admission- Patient health history, Risk assessments, Medication Management plan	2-4 hourly vital signs & vasc obs or more frequently if patient condition changes
Admission 12-lead ECG	Telemetry cardiac monitoring – check and set alarms. TDS rhythm strip analysis
Patient has correct ID band – 3 forms of patient identification	Daily 12-lead ECG
	Pacing wires (if no longer required) – wearing gloves, isolate and cover with gauze and occlusive dressing. If removal indicated – withhold clexane 12 hours prior and remove as per hospital policy
Consent form by surgeon and patient	Daily CXR
Operation checklist commenced and completed when possible	Review by physiotherapy
Patient measured to knee length TEDs (2 pairs)	1/24 DB&C
Pre-op shave (AM case the night before, PM case morning of). Shave checked by RN	Effective pain relief – ensure QID Panadol
Pathology – CUEs, APTT&INR, FBE, Hep B & C, Group and Crossmatch 2 units of packed cells	Tolerating prescribed diet
Chest x-ray (AP/lat) in department- order hard copy to be sent to ward	Strict FBC, 1.5 fluid restriction
Accurate patient Height and weight recorded, no estimation	IDC insitu or monitor urine output. Daily
Urinalysis	Urinalysis
Patient orientated to ward and visit ICU	Document bowel action and bowel sounds – consider aperient
Patient and family view	Wounds – assess TDS. Applt betadine to suture and drain tube sites daily. RAG supported by tubigrip
CABGs/AVR video	ICCs- if insitu, check insertion site. 1/24 documentation of air leak, swing and drainage. Assess correct connection to suction. If for removal as per surgeon, remove as per protocol
Patient fasted as per anaesthetist	Vascular access – IVC or CV. Observe site for signs of infection. Flush TDS
Patient showered x2 with betadine scrub	SOOB as tolerated, encourage ambulation
Pre-med administered as per orders	Assist with shower/ sponge
Oxygen @6l/min post pre- med, Patient to be transported to theatre on trolley with oxygen	TEDS insitu during the day-remove at night

The following has been completed:

Cardiac x 14

Respiratory and Thoracic x 5

Medical x 9

Orthopaedic and Neurosurgery x 15

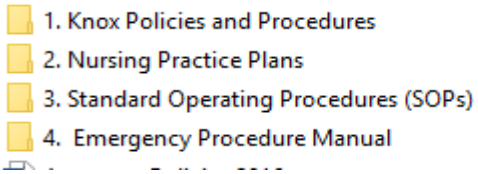
Urology x 11

Paediatrics x 1

End of Life x1

2019 September:

Nursing Practice Plan - Subdural Haemorrhage Pre- operative Care, Conservative Management; Post-operative Care discussed with Nurse Educator Orthopaedics. To develop a specific Nursing Practice Plan, separate to a craniotomy NPP. This is a result of an incident and identification of the learning needs the nursing staff on the orthopaedic ward.



Completion Due By: 2018 December

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Clinical Guidelines and Nursing Practice Pathways available on the intranet have been reviewed in line with this recommendation from the previous survey. The assessment team agrees that the intent of the recommendation is met, and the recommendation is now closed.

Standard 4

Organisation: Knox Private Hospital
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

Recommendation NSQHSS Survey 1016.4.1.2 :
Ensure that the organisation consistently obtains telephone order sign-off within 24 hours to meet legislative requirements and comply with KPH policy and procedure.

Organisation Action:

Compliance with telephone order sign off within 24hours to meet legislative requirements and compliance with KPH policy and procedure.

Actions taken:
2017 Department random audit of PBS Medication chart telephone orders - not signed within 24hrs.
Department results varied between 5 - 30% compliance across the clinical departments.

2018 Department random audit of PBS Medication chart telephone orders - not signed within 24hrs.
Department results varied between 5 - 100% compliance across the clinical departments.
Coronary Care Unit = 100% compliance
Intensive Care Unit = 71% compliance
General Medical / Surgical wards = 5-71% compliance.
Chesterfield Ward = 71% compliance

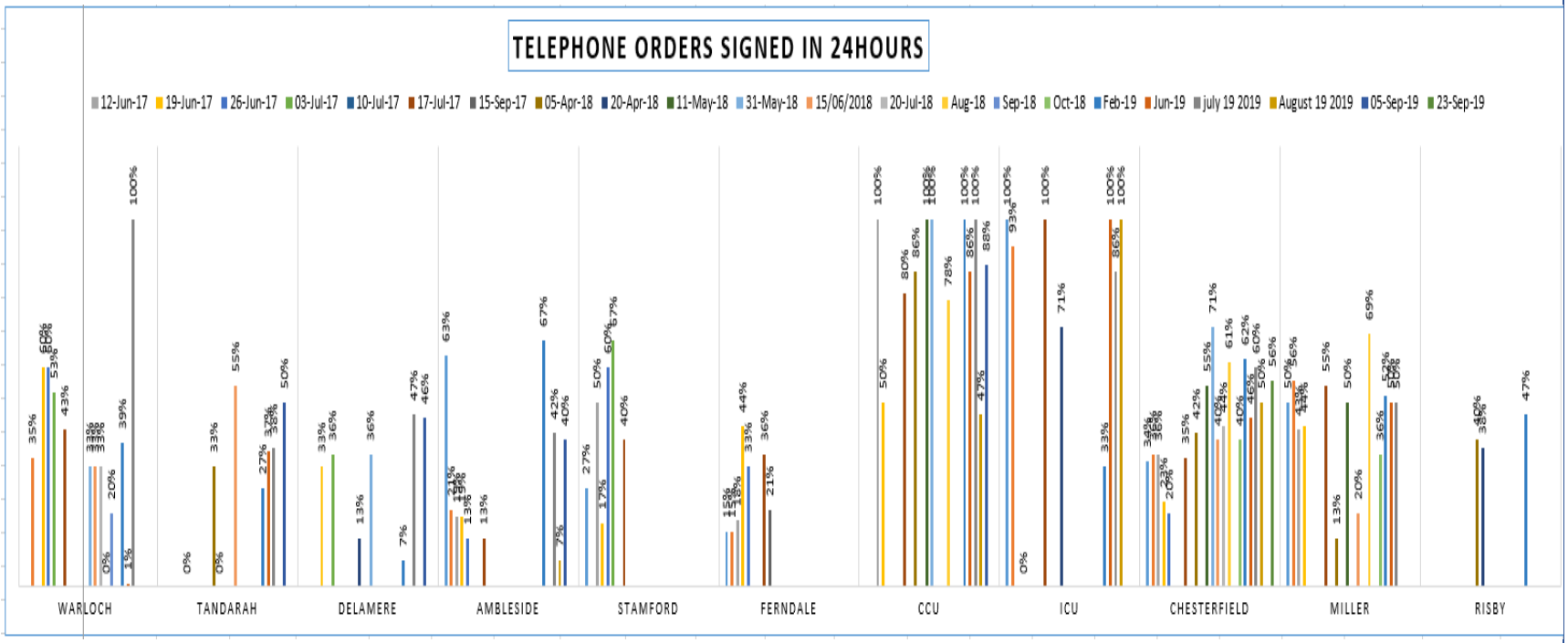
Issues identified:

- Anaesthetist pre and post-operative telephone orders not signed; VMO telephone orders on the last day of a rotating roster not signed.
  Action taken:
- Nurse Unit Manager, Nurse - in - Charge of the wards, bedside nurse reminds VMOs to sign telephone orders when present.
- Quality Manager provides name of VMO's from random audits to Executive and GM reports for notification.
- Laminated reminder insert sheets next to PBS Medication chart to notify VMO's of telephone orders to sign. (bright green)
- Laminated reminder insert sheets next to PBS Medication chart to notify Anaesthetists of telephone orders to sign. (bright orange)

- HSP Medication Cluster: Discussion on 24hr telephone order compliance and ideas for obtaining compliance. National Clinical Risk Manager present for discussion.
- KPH Pharmacy Committee: 24hr telephone order - agenda item for each meeting
- KPH Executive: Correspondence to VMO's on legislative compliance responsibility and requirement to sign telephone orders.

2019:

Audits: Ongoing department audits for compliance with VMO signing in telephone orders within 24hrs



2019 August unsigned telephone orders:

Chesterfield: Night duty team is checking all medication charts for unsigned phone orders; VMO's reminded and asked to sign on ward rounds or verification messages are sent verifying the audit

Ambleside: No action plan submitted. Email to NUM as low result idnetified and urgent action required.

Quality Manager met with Medical Director and provided list of Key VMO's not signing 24hrs telephone medication orders as per names provided by NUM's.

Communication:

Nurse Unit Managers remind nursing staff to ask Visiting Medical Officers to sign telephone orders at the time of patient rounds

2019 May: Director of Nursing Quality agenda included discussion on telephone order compliance

2019 August: Quality Manager met with Medical Director regarding VMO Compliance related to signing of telephone orders. The names of VMO's who are primarily non-compliant with the signing of telephone orders were provided to the Medical Director.

2019 September: Medical Director attended the Quality Committee and was a participant in the telephone order discussion with the Nurse Unit Managers related to VMO non - compliance for signing of orders.

Healthscope communication:

Healthscope Shared Learnings provided guidance to assist nursing staff to obtain increased compliance with the meeting of legislative compliance of the authorisation of telephone orders as per the PBS guidelines.

3. MEDICATION SAFETY

3.1. MEDICATION ORDERS - VERBAL

Policy Reference: 18.50 Ordering Medication – Verbal | 18.01 Medication – Orders and Administration

ACTION (POLICY)

Verification of the Verbal Medication Order

The verbal order is to be verified within 24 hours of the order being made, by the authorising medical practitioner by either:

1. **Signing the medication order**, or
2. **Verifying via text message or email**:
    - If the relevant state/territory legislation does not permit this form of verification by text or email then the medical officer must sign the medication order
    - The nurse must use a **designated hospital smart phone** which is to be held by the Nurse Unit Manager, After Hours Manager, or senior registered nurse (after hours).
    - **Staff personal devices are not to be used** in any circumstances
    - A photographic image of the verbal medication order is to be taken, which must include:
        - The full verbal medication order documented on the medication chart
        - The patient details (label) – full name, date of birth, MRN, gender
    - The photographic image is to be texted or emailed to the authorising medical officer using the mobile phone number or email address of the authorising medical officer listed in WebPAS
    - The authorising medical officer must **verify the verbal medication order** by return text or email
    - For the **verification to be accepted**:
        - The authorising medical officer must state in the return text message or email – ***"verified and approved"***, and
        - The **full name of the authorising medical officer** must appear in the return text message or email
    - The verifying text received from the authorising medical officer is to be printed and placed in the clinical record with the medication chart
    - The printed verification placed in the medical record must include:
        - The original text message or email sent to the authorising medical officer
        - Date and time the original text message or email was sent
        - The verifying text message or email received from the authorising medical officer
        - Date and time the verifying text message or email received
        - Signed and dated by the staff member entering the text message or email exchange in the medical record

Only facilities that are able to **accommodate all aspects of the above** process may use text message or email verification.

The process is to be discussed at the facility:

This has had limited success to ensure compliance with legislative requirement for telephone orders.

The wards have laminated signs in place at the red bedside patient folders to alert VMO's of telephone orders to sign.

Nurse Unit Managers meet and continually discuss strategies for obtaining increased compliance for the signing of telephone orders.

Completion Due By: October 2019

Responsibility:

Organisation Completed: No

Assessor's Response:

Recomm. Closed: Yes

Evidence relating to this recommendation has been reviewed, with many initiatives being implemented. The assessment team agrees that the intent of this recommendation has been met. The recommendation is closed.