NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Ringwood Private Hospital

Ringwood East, VIC

Organisation Code: 220194
Health Service Facility ID: 101103
Assessment Date: 22/10/2019 to 24/10/2019

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

Ringwood Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 22/10/2019 to 24/10/2019. The NS2 OWA required 2 assessors for a period of 3 day(s). Ringwood Private Hospital is a Private organisation. Ringwood Private Hospital was last assessed between 7th March – 9th March 2017. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Ringwood Private Hospital	101103

General Discussion

Ringwood Private Hospital (RPH) provides a range of medical, surgical and day procedure services to their community. The Oncology service is very impressive and highly regarded.

Lead by a dedicated and committed Executive team it was evident care and services are delivered safely. The assessors extend they're thanks to the General Manager, department managers, Visiting Medical Officers (VMOs), staff and consumer consultants for their active participation during the assessment.

The assessors appreciated the comprehensive information provided prior to the assessment and at the time of the assessment. Evidence was available to support the hospitals self-ratings of Met in all National Safety and Quality Health Service Standards (NSQHSS) second edition.

Major changes to the quality KPIs at corporate level have also been implemented in September 2017. Defining the four (4) pillars of priority these are, Quality Clinical Outcomes, Exceptional Patient Care, Creating Extraordinary Teams and Delivering Market Lead Financial Returns.

Particularly pillar one (1) Quality Clinical Outcomes and pillar two (2) Exceptional Patient Care has refocused and prioritised the way in which care is delivered for the hospitals and supports the Back to the Bedside and Rework projects as well.

The Executive and staff at RPH have embraced the future direction of Healthscope and welcome the changes.

RPH has a comprehensive clinical and corporate governance structure with robust systems to manage quality and risk. The information is well documented and provides evidence of indicators and outcomes to measure and improve performance.

Healthscope corporate services in collaboration with the clusters oversee and provide a raft of evidence based clinical policies and guidelines available on the Healthscope Intranet (HINT) to support clinicians at the bedside.

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

The patient clinical record is well integrated and appropriate to good patient care. However, there have been two (2) Met with Recommendations for Actions 6.4 and 6.11 Communicating for Safety Standard in regard to clinical content and clinical handover in the post-anesthesia care unit (PACU).

Credentialing and Scope of practice is managed in accordance with Healthscope policies and By-laws.

Performance and skills management is well done with established systems in place to support, monitor and evaluate performance across all disciplines. Staff education and training in respect of patient safety and quality is comprehensive.

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

Patients' Rights and Responsibilities are well respected and included in information compendiums, brochures, the website and at the point of care.

Consumer participation is actively sought. The engagement of patients' families and carers in activities that improve safety and quality was evident. The Consumer Consultants have provided a great deal of suggestions for improvement at all levels.

Preventing and Controlling Healthcare Associated Infections is well embedded in every day practice in all clinical units and support services. Whilst some departments of the hospital are ageing, the hospital is impeccably clean, tidy and well maintained. The low infection rate is testament to the efficacy of the systems. The transition to AS/NZS 4187:2014 is proceeding and plans to refurbish the CSSD are under review.

There are established processes in place to manage medication safety. Documentation of patient information, continuity of medication management and the reconciliation of medicines are audited regularly with good results.

Comprehensive Care strategies and procedures are in place to provide continuous and collaborative care. The Comprehensive Care Plan implemented in August this year has addressed key care criteria and audits are in place to identify areas for improvement. Patients and carers are involved and encouraged to participate in their care which includes screening and assessment, shared decision-making, goals of care, care plans and at end-of-life wishes.

Communicating for safety includes patient identification and procedure matching, transfer of care and matching of patients and their care are well documented and audited for compliance at every point of care of the patient's journey.

Clinical Handover is well done - with good local processes developed in collaboration with clinicians, patient and carers. The information provided on the patient care whiteboards is very impressive.

Blood management systems and blood product transfusions are safe, appropriate, effective and efficient.

Skilled, caring and responsive staff are extremely well educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient or child's health status. There has been a Met with Recommendation for Action 8:10 Recognising and Responding to Acute Deterioration Standard in relation to Doctors Basic Life Support (BLS) training.

In summary, RPH should be proud of their good work, their innovation and their achievements in improving care and services.

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

Summary of Results

At Ringwood Private Hospital 's Organisation Wide Assessment 3 Action(s) were rated Met with Recommendation across 8 Standards. The following table identifies the Actions that were rated Met with Recommendation and lists the facilities to which the rating and recommendation applies.

Actions Rated Met With Recommendation	Action and Recommendation	Name of Health Service Facilities where action was deemed to be Met With Recommendation
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. **Recommendation:** Review, develop and document a Post Anaesthetic Care Unit (PACU) discharge criteria for patient discharge to the wards and day procedure unit.	All Facilities under membership
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. **Recommendation:** RPH review best practice medical record documentation to ensure accurate statements of clinical interactions between the patient and treating doctor relate to assessment and diagnosis, care planning and treatment. Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient to provide ongoing care at any time.	All Facilities under membership

Actions Rated Met With Recommendation	Action and Recommendation	Name of Health Service Facilities where action was deemed to be Met With Recommendation
8.10	The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration. **Recommendation:** The Basic Life Support (BLS)/ Cardiopulmonary Resuscitation (CPR) training status of the Medical Officers to be recorded by RPH according to the Commissions Advisory relating to this.	All Facilities under membership

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

Ringwood Private Hospital

Sites for Assessment

Sites for Assessment - Ringwood Private Hospital

Ringwood Private Hospital HSF ID:101103	
Address: 36 Mt Dandenong Rd RINGWOOD EAST VIC 3135	Visited: Yes

Ringwood 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:

Ringwood Private Hospital (RPH) has a well-defined corporate and clinical governance structure appropriate for the range of services provided by the hospital. Clinical and support staff involvement in safety, quality and risk management is clearly demonstrated.

There is a range of Healthscope corporate and cluster policies and procedures in place, along with local polices as deemed applicable.

Policies are easily accessed on the Healthscope Intranet (HINT). The Healthscope Corporate Document Controller (CDC) is responsible for the management of Healthscope's policies and procedures document control system whereby all polices are kept up to date and are readily available to all staff.

Legislative changes are monitored at corporate level and the hospital is informed of any changes that may be required.

The Healthscope Clinical Governance Framework forms the basis in decision making and this is evident in the strategic and business plans for the hospital.

The hospital's organisation and committee structure support the overall governance of RPH.

The accessors acknowledge the good work undertaken by the Quality Manager and the committees to review the timeliness and relevance of audits and to clearly focus on outcomes and areas for improvement.

The Medical Advisory Committee (MAC) is actively involved in all aspects of clinical care. The information provided to the members, particularly the comprehensive clinical indicator set, is well documented and reflects the hospitals clinical performance. For example, credentialing, infection control, morbidity and mortality, risk and adverse events are all standard agenda items. In addition to ACHS Quality indicators, the hospital participates in benchmarking activities with similar peer group hospitals within the Healthscope group. RPH results are in the top rankings which are to be congratulated.

Staff are aware of their roles and responsibilities in all aspects of quality and safety. Position descriptions are in place and annual performance reviews conducted.

Workforce planning, performance management and education are of high priority. Review and evaluation are occurring at all levels.

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:

The risk register is managed by the hospital. Each identified risk has a risk rating and linked to a mitigation strategy. There is a work currently underway to review all the risks on the register to ensure the status of the risk is relevant in the aim to reduce the risks and highlight the risks needing attention.

The hospital's organisational wide quality improvement system is overseen by Healthscope Corporate. The extensive suite of indicators is well documented and reports are discussed at committees and department level. The executive also reviews the quality action plans of each department.

Incidents and complaints are reported and recorded on RiskMan, the incident management system. Information is provided to the management and staff, the MAC and to Healthscope Corporate Office. Significant results or events are also published on the Healthscope wide Shared Learnings which is a very constructive way of disseminating outcomes and lessons learnt to the staff.

An open disclosure policy is in place. If an event occurs that requires such disclosure, support from Healthscope is readily available to assist the management and staff.

Feedback from patients is highly sort through patient satisfaction surveys, face-to-face conversations and by the Qualtrics feedback system which captures patient's comments in real-time. Cultural diversity is well respected in every way.

In regard to the patient's health record, the assessors suggest the hospital undertake a review of the information and contained in the record with a focus on the clinical content and the collation of the health record to ensure the record is meeting relevant standards and guidelines. This review will support the Met with Recommendations for Actions 6.4 and 6.11 Communicating for Safety.

There are detailed Healthscope policies and procedures in place to support hospitals regarding the implementation of the My Health Record (MyHR) system. The MyHR system was implemented during 2015/16 at all Healthscope hospitals. Event summaries (admission notifications) and Nursing Discharge Summaries determined by patient consent are uploaded to MyHR and this is highly automated.
RPH has conducted a detailed gap analysis identifying timelines and activities in accordance with Advisory AS 18/11.

RPH has also implemented a MyHR consumer materials starter pack updated following the close of the opt-out period. The materials assist patients to understand the benefits of having a MyHR and how to access and control their record. Over the last 12 months – the uptake has steadily increased by 45% from 2018 to 2019 to date.

It is anticipated that MyHR record will be embedded into routine clinical workflow as the electronic medical record (EMR) is implemented across Healthscope hospitals in the future.

There is a Healthscope policy clearly outlining the authorised access to the MyHR with that being the General Manager at RPH following written consent.

Healthscope authorised IT personnel have access for the purposes of monitoring the quality of the download of the event and discharge summaries that are uploaded to the MyHR and Healthscope has also assigned the Privacy Officer responsibilities to the National Claims and Litigation Manager who in turn reports to the Chief Medical Officer.

The introduction of the health record "Drop Down" boxes to be installed outside each patient room is a great initiative and will assist in ensuring clinical staff enter their orders and notes in a timely way. A suggestion has been made to support the review of clinical documentation.

Laminated reminder cards have also been introduced in regard to the signing of telephone orders by the doctors which appears to be working well. This system has been extended to remind doctors to complete discharge summaries as well.

Clinical coding is of high priority and is a project across all Healthscope hospitals. The recent appointment of the Health Information Manager (HIM) will further strengthen the management of coding KPIs. Executive huddles are held regularly, this allows the Health Information Manager (HIM) to quickly identify any discrepancies as well as Length of Stay (LOS) outliers. If required education can be actioned in a timely way either by "Huddle Sessions" or further audits.

Suggestions for Improvement:

The assessors have suggested to review the current forms and the documentation contained in the progress notes, in particular the clinical entries and accuracy. Colour coded standard forms, clearly labelled dividers and designations highlighted in the progress notes, would certainly make it easier for staff and VMOs to find information easily within the record. Various documentation audits are conducted to address compliance. It has also been suggested that the hospital undertake an internal audit in relation to doctor's discharge summary compliance and the use of abbreviations such as Left and Right to ensure this is meeting the Healthscope policy.

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:

Workforce planning, performance management and education are of high priority at RPH.

Staff orientation is provided at the commencement of employment and has been extended to meet the needs of the new employee. A mandatory training schedule is in place and incorporates, eLearning packages, face-to-face education and training, as well as competencies applicable to the specific disciplines. The monitoring of the education program is managed well; on average 90% compliance has been obtained in all the mandatory topics.

A high focus is placed on orientation, mandatory training and education and training for all staff. Underpinned by Healthscope corporate policies, KPIs and performance appraisal systems RPH ranks highly in this regard.

Training in Aboriginal and Torres Strait Islander (ATSI) cultural safety has commenced at RPH in 2019 with good compliance noted.

Clinical services are governed by a raft of best practice clinical guidelines. Compliance is monitored through rigorous reporting of adverse events, near misses, results from audits, patient complaints and feedback. There are validated risk assessment tools used for assessing all patients on admission. Those deemed “high-risk” or at risk of harm are then subject to further screening and assessment. Benchmarking occurs at peer group level and monitored by the cluster committees. Serious breaches are reported to Healthscope Corporate Office.

There are clear exclusion criteria and guidelines that outline the procedures that can be performed safely and within the clinical capabilities of the hospital. A high focus has been placed on paediatrics. Significant VMO consultations and staff training has been conducted as well as a review of Paediatric resuscitation procedures and equipment. Paediatrics remains as a high-risk on the risk register and activity is monitored diligently.

If, however, there is an unexpected deterioration in a patient or child's health status, there are well qualified medical and nursing staff available to assist. Emergency support is provided by the ambulance service Mobile Intensive Care Ambulance (MICA) and there are good relationships established with Knox Private and Maroondah Public Hospital if the need arises.

All Visiting Medical Officers (VMOs) appointed to the hospital are subject to the Healthscope credentialing process and defining of their specific scope of clinical practice. The credentialing procedure is clearly outlined in schedule five (5) in the Healthscope Bylaws. The new e-Gov credentialing system enables the medical staff and allied health professionals the ability to go on line and register their application and or re-credentialing requirements. Healthscope and the hospital are now able to review these applications remotely. This system overtime will eliminate the need for a paper-based system. New appointments and re-appointments are reviewed by the Medical Advisory Committees (MAC) along with any new procedure. Information on the scope of practice is also made available to key members of the clinical staff and Operating Theatre Manager.

Members of the nursing and allied health staff have their scope of practice defined in their position descriptions or contracts. Staff appraisals include competencies and are conducted annually measured by a number of performance indicators applicable to the employee's role.

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:

There has been a high focus from the Executive to ensure the hospital maintains a safe environment for patients, staff and visitors. The preventative maintenance program is very well managed which includes an asset and equipment replacement plan. The Essential Services Permit was clearly displayed and good evidence was sighted regarding the management of contractors.

Cleanliness and good housekeeping throughout the hospital and surrounds was obvious. Patient accommodation is welcoming and visiting hours flexible. It was noted however that Derwent Ward, which is the oldest ward in the hospital, is due for refurbishment with plans underway. The Day Oncology Ward has also been sighted for refurbishment as well.

The signage externally and internally is clear and easily understood and is respectful of all cultures including Aboriginal and Torres Strait Islander people.

It was evident that Occupational Health and Safety (OHS) is of high priority and training is provided to all staff and contractors. Reporting and issues of concerns are brought to the attention of senior executives.

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:

RPH is to be congratulated on their engagement with consumers and the wider community.

Healthscope Safety and Quality Plan in conjunction with the "Patient Partners" Consumer Engagement Plan 2016-2019 plus policies, procedures and protocols specific to partnering with consumers, are clear and guide hospitals on how to engage with consumers in all aspects of care and service provision.

The second pillar Exceptional Patient Care four (4) outcome statements are testament to the drive and commitment by Healthscope to ensure Patient-Centred Care is at the forefront. The in-depth Rework project includes clinical and support services engagement, with oversight managed at corporate level. KPI's relevant to these projects are in place to measure performance and to ensure consumer feedback is timely.

In 2018 Healthscope established the Aboriginal and/or Torres Strait Islander Cluster. Both Aboriginal and non-Aboriginal consumers are represented. The cluster governs all activities and oversees the Aboriginal and Torres Strait Islander project.

There is a consumer consultant role description that articulates responsibilities. The Consumer Consultants meet regularly to discuss and review strategic and operational business including quality and risk data, education for staff and patients, consumer brochures and environmental risks.

There is a clearly defined orientation foundation program for consumer consultants. The training information packs are well designed, comprehensive and easily understood. There are both formal and informal processes that enable consumer feedback on healthcare publications. There are also feedback forms such as ‘your impression of us’ which has now transitioned to the electronic platform Qualtrics. Response rates at RPH are increasing and feedback provided in real-time.

Partnering with patients in their own care

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

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

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

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

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

The Australian Charter of Healthcare Rights is well displayed throughout the hospital.

Patients are actively involved in their care and consent for procedures well explained and documented. Consent processes include clinical consent and informed financial consent. Interpreter services are available if the need arises. There is a suggestion to review the timeliness of patients signing of consent.

Feedback is also gained from the patient experience and Patient Centred surveys.

RPH is a relatively short stay medical and surgical hospital with a busy Day Surgery Unit and Oncology service specialising in oncology treatments and care. Advanced Care Directive (ACD) policies and procedures are in place and assist VMOs and clinical staff to respect and acknowledge patients requests in this regard. There are also policies and procedures and alert systems relating to Not for Resuscitation (NFR) orders, if applicable.

Patients privacy and confidentiality are managed well and all staff are aware of their responsibilities.

Suggestions for Improvement:

The assessors encourage the hospital to review the policies and procedures regarding the timeliness of when the patient signs their informed consent. At present, patients are consenting to their procedures on the day of admission and in some cases just prior to their procedure. Whilst this is compliant with the Healthscope Consent Policy, it would appear to be not best practice, and informed consent should be obtained by the VMO/Proceduralist prior to the patient's admission. It is also suggested that the obtaining of consent for open access endoscopy be reviewed as well, and in accordance with the current Commissions Advisory 18/12.

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:

There has been a raft of projects and health promotion activities at RPH which have been driven by feedback from patients, consumer consultants and community service groups.

Brochures and information leaflets have been reviewed with input from the Consumer Consultants and staff.

Reading some of the current brochures, the layout and information is clear, concise and well presented.

A wealth of information is provided to patients and families regarding hospital services. The Consumer Consultants are well engaged in ensuring patients and families are provided with up-to-date information.

They also review patient satisfaction surveys, complaints and compliments and have significant input into the publication of booklets and brochures. The website is also another area the consumers can provide feedback and assist with the content.

The assessors were impressed by the commitment and engagement of RPH Consumer Consultants thus far.

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:

RPH has two (2) Consumer Consultants that are well engaged in assisting the hospital and encouraging patients to tell their stories.

There is a consumer consultant position description and orientation program that articulates responsibilities. It was clearly evident when talking with the consumer consultants their understanding of their role and their passion to help patients and their families.

The consumer consultants meet regularly with the Quality Manager to discuss responses from patient's visits using a very simple questionnaire. The consultants also attend and participate at committees and meetings and are able to have input into service improvements and patient feedback.

My Healthscope and MyHospital websites provide clinical outcome data to the general public to access at any time for example, falls and pressure injury rates, hand hygiene compliance and unplanned re-admission.

There is also a feedback form which has now transitioned to an electronic form. Every patient who has provided an email address is automatically sent a feedback questionnaire to complete. RPH has experienced an increase in response rates in their patient experience survey since the electronic form has been introduced. Results are extremely complimentary.

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 control system is well established and managed diligently. Healthcare Infection Control Management Resources (HICMR), the Infection Control Consultants, provide a comprehensive range of evidence-based policies, procedures and audit tools in accordance with the Australian Guidelines for the Prevention and Control of Infections in Health Care.

The Infection Control Risk Management Plan is comprehensive and managed by a dedicated multidisciplinary Infection Control Committee.

The risk management approach to infection prevention is highly impressive. Safety and Quality Action Plans have been implemented in accordance with the identified risks documented on the risk register for example, Sterilisation and Central Sterilising & Supply Department (CSSD) AS/NZS 4187:2014 compliance.

It was evident at the time of the assessment that the hospital has engaged with patients and consumers in relation to infection control prevention and antimicrobial stewardship. Information regarding hand hygiene was well displayed in all clinical departments; pre-admission and assessment tools also provide patients with information regarding risk factors and the management of infectious diseases. Feedback is being sort and evaluation occurring. The hospital is encouraged to keep up the good work. Consumers are also able to view results on the MyHospitals Website.

Infection control surveillance is monitored through, pathology results, risk assessments and screening, incident reports and compliance audits. Reports are tabled at the Infection Control Committee, including the Medical Advisory Committee (MAC) as well as at department level. Clinical indicators are reported and bench-marked across the Healthscope Hospital Group.

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 precautions and transmission-based precautions are monitored regularly in accordance with policies and procedures and national guidelines. HICMR audit toolkits are used to evaluate adherence to policies. Results are reported at the appropriate committees including the MAC. An alert system on the Patient Admission System (WebPas) is in place if a patient has been identified as a risk. Isolation procedures are in place if the need arises. The introduction of "PPE" stations on individual patient doors if a patient is deemed an infectious risk is a very good initiative. Signage is posted in all departments and public areas.

Hand Hygiene is deemed a high priority and continues to be reviewed throughout all clinical and non-clinical areas in accordance with the hospitals Hand Hygiene Management Plan and hand hygiene guidelines. Staff education commences at orientation and regular information sessions are conducted internally and externally. ELMO eLearning packages are required to be completed as part of the education program; this includes the training of Hand Hygiene Auditors. Results from audits are reported to the appropriate committees and service areas. The staff hand hygiene compliance rate is over 92%. There has also been a focus on "Bare to the Elbow," compliance is 96%.

Surgical Site Infection Rate is 0% for this reporting period.

There has also been considerable work undertaken in regard to Aseptic Technique. Procedures have been identified and competency-based assessment tools are in place. It is suggested VMOs should be included.

Policies, procedures and audits are in place to enable the hospital to manage the use of invasive devices safely. Intravascular device management guidelines and competency-based training tools and flowcharts such as, the Body Fluid Exposure Flowchart are used to ensure clinicians are provided with education applicable to their discipline.

The cleanliness and maintenance of the hospital and grounds are to be congratulated.

There are policies and procedures in place for the management of clinical and non-clinical waste, cytotoxic waste and sharps disposal.

Signage was evident throughout the wards and patient areas clearly displaying the importance of infection control by all.

The Catering Department is Hazard Analysis Critical Control Points (HCCAP) accredited and complies with local regulations and inspections. Food production and menu monitoring caters for patients in every way.

Laundry services are contracted and managed well in regard to clean and dirty segregation.

Environmental audits, as well as Food Safety Audits, are conducted regularly. Results indicate a very high standard is maintained. Staff education and training is ongoing.

Material Safety Data Sheets (MSDS) are kept in the relevant cleaning and service areas for easy access for staff.

Chemical training for staff is mandatory.

The Supply Department is well managed, clean and clutter free.

The staff immunisation program is well documented and monitored in accordance with corporate policies. The staff health program includes staff health assessments and screening, vaccinations and education and training. Staff are encouraged to participate and contribute to their well-being. Patients are also included in education and vaccination programs.

RPH's low infection rate is testament to the robust systems in place to monitor infection control practices across the hospital.

Suggestions for Improvement:

Whilst there is a high aseptic technique compliance rate for staff, it is suggested that VMOs performing high risk procedures are included in Aseptic Technique education.

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:

The hospitals cleaning, disinfection and sterilisation practices are managed in accordance with AS/NZS 4187:2014, Gastroenterological Nurses College of Australia (GENCA) guidelines and The Australian College of Operating Room Nurses (ACORN) Standards. A gap analysis has been conducted and an action plan is in place.

The design and layout of the current CSSD and the segregation of clean and dirty remains a challenge for staff; however, there are good processes and regular auditing to manage the risk of cross contamination. Staff are continually provided with education and training and all competencies are recorded.

Instrument tracking is in place and all validation records are recorded for sterilisers, dishwashers, ultrasonics and dryers. The reprocessing of scopes is also diligently monitored and recorded.

There has been some very good work conducted in regard to the segregation and location of sterile stock with the introduction of stainless-steel shelving as well as the introduction of custom packs to eliminate the use of linen.

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:

The Antimicrobial Stewardship Program continues to provide positive evidence of improvements at RPH associated with antibiotic usage and prescribing patterns. HPS Pharmacy are to be congratulated on their good work in relation to the monitoring and use of antibiotics.

The NAPS (National Antimicrobial Prescribing Survey) is also used to address compliance to guidelines and the appropriate use of antibiotics. An antibiotic formulary is in place to support prescribing best practice.

Antimicrobial stewardship is a standing agenda item at the MAC.

RPH is also a member of the Eastern Cluster Antimicrobial Stewardship Committee.

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 Safety policies, procedures and protocols are in place and managed in accordance with National and Jurisdictional Legislative requirements. Prescribing, dispensing, administration, storage and supply are all managed well. The Healthscope National Medications Webex Team has been established in 2019 and provides a forum for discussion for all hospitals to contribute to improvements in the management of medications.

Medication errors and adverse events are reported on RiskMan. The medication management system is regularly monitored by a range of activities and audits including the Medication Safety Self-Assessment (MSSA) and Ward Drug Audits.

Medication incidents are discussed at the Medication Safety Committee and reported at the Patient Care Committee (PCC) and MAC. Staff are required to use an internally developed reflective practice tool if they are involved in any medication error incidents.

Hospital Pharmacy Services (HPS) Clinical Pharmacist is also actively involved in all aspects of medication safety.

There has been some very good work undertaken due to a chemotherapy administration error. The hospital has introduced a time-out checking procedure for all oncology patients receiving chemotherapy infusions, as well as the use of an instruction sheet. There are negotiations underway with Healthscope and HPS to introduce the CHARM electronic prescribing systems to minimise the risk of administration errors.

HPS also have production pharmacists on-site for the compounding of chemotherapy drugs. This is a very welcomed service; however, it is noted that the area is very small and will need to be reviewed as demand increases.

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 obtained from all patients at the time of admission. A Medication Management Plan is used for all oncology, medical and surgical inpatients. The RPH Medication Reconciliation Flowchart and Medication Management Plan include the medication reconciliation process on admission, transfer and at the time of discharge.

Patient's current medications are recorded at the time of admission and documented on the National Inpatient Medication Chart (NIMC) and or Medication Management Plan by the clinical staff in consultation with the patient. Medication alerts and adverse drug reactions are recorded in the patient's medical record and at the bedside. This is routinely audited and evaluated. Medication errors resulting in an adverse event is less than 0.01%.

As part of the admission, patients are required to complete a Patient Health History which also incorporates questions specific to medication management.

The Clinical Pharmacist provides medication profiles and education to patients if new medications have been prescribed or if medications have changed. Medication reconciliation occurs at the time of discharge and is well documented.

A nursing discharge summary is a secondary source of relevant medication information that is provided to the receiving clinicians during clinical handover and upon discharge back to the GP.

Medication formulary lists include a restricted antibiotic list and are used when prescribing.

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:

Patients, families and carers have the opportunities to discuss medications at any time with clinicians. Purposeful rounding and bedside handover also provide the patient with further opportunities if they have concerns.

Information booklets are provided and consumer medication information leaflets are available in the ward and day surgery and are given to patients on discharge.

The Clinical Pharmacist is involved in this process which is well established and effective and is actively engaged with patient's medication management.

Patients and staff have access to HPS Pharmacy to seek advice and information if required.

Feedback from patients is very positive.

Staff position descriptions include medication responsibilities and provide guidance on scope of clinical practice.

Education is of paramount importance and a mandatory education module specific to medication management for registered and enrolled nurses ‘Med Safe’ is in place.

Medication formulary lists include a restricted antibiotic list and are used when prescribing.

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 are a range of decision support tools and resources to support the clinical workforce at the point of care such as eMIMS and eTherapeutic Guidelines (eTG).

Internal monitoring systems and regular audits are conducted to review the secure storage and safe distribution of medicines throughout the hospital. The new ward and theatre drug rooms are extremely well organised. "High-risk", look-alike sound-alike medications, Dangerous Drugs Act (DDAs) and injectables were clearly labelled.

Receipt and disposal of unwanted and expired medications is managed by HPS throughout all clinical areas.

Fridges housing temperature sensitive medications are monitored daily. The assessors have suggested investigating a central monitoring system that monitors all fridges including the kitchen.

Suggestions for Improvement:

The assessors have suggested that the hospital investigate a centralised system for monitoring all ward fridges housing temperature sensitive medications as well as the fridge and freezer temperatures in the kitchen and departments such as the operating room that close after hours to ensure any breaches are captured in a timely manner.

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:

Healthscope and Ringwood Private Hospital (RPH) leaders and management staff have set up and maintain systems and processes to support the delivery of comprehensive care. There are also systems in place to prevent and manage specific risks. The recently implemented care plan assessment and documentation supports clinicians to deliver comprehensive care. It allows for timely referral and shared knowledge of the patient's condition and care plan. Meaningful development and implementation of this process has required involvement of patients, consumers and families. Collaboration of the care team, patient and family is well developed and was observed during the assessment visit. This is enabled by the close working environment in the wards, the bedside patient handover and the identification and documentation of the patient's goals for care.

The ward is not of contemporary design but work has been undertaken to make the environment as patient focussed as possible with quiet areas for families and patients to interact outside the patient room. A small gym area is also available. The restricted staff areas such as the blood fridge and medication rooms have been de-cluttered and have new purpose-built shelving installed to aid and reduce risk in care delivery.

Patient and carers are involved in the clinical bedside handover. The new Patient Care Board was developed with patients and the Consumer Consultant and provides an opportunity for patients to identify their goals for the day and in the care planning process. Pre-admission or admission screening is conducted to ensure any specific needs of the patient are identified and assists with commencing discharge planning. The Comprehensive Risk Assessment guides referral to the multidisciplinary team to ensure patients' needs are met. This includes Speech Pathology, Dietician, Social Work, Physiotherapy, Pharmacy, Podiatry, Diabetic Educator, Cancer Support Nurse, Stomal Therapy and Specialist medical practitioners including psychiatrist and palliative care physician.

The risk assessment incorporates screening for falls, pressure injury high risk medications, malnutrition, cognitive impairment, venous thromboembolism (VTE), Infection control, Mental health history, Behavioural history and skin assessment.

Ringwood Private Hospital monitors comprehensive care through the review of incident reports, audit results, HAC (Hospital Acquired Complication) rates, ACHS clinical indicator reports and patient feedback. These are reported and reviewed at RPH Committees.

Suggestions for Improvement:

The Comprehensive Care assessment and documentation has only recently been introduced (August 2019) and will require ongoing attention to ensure they continue to be used appropriately and are embedded in practice.

The patient bedside handover has been encouraged and supported by the Nurse Unit Managers to ensure compliance.

It will be important to continue these processes to further strengthen how the clinical team works with patients and families to ensure shared decision-making is represented in a comprehensive and at the same time individualised care plan for every patient. Patient stories could be recorded and communicated to all staff as a means of keeping attention on the importance of patient involvement in their care planning.

Developing the comprehensive care plan

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

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

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

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

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

Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Risk screening is well developed and strategies to address comprehensive care requirements as a result of this screening were observed during the assessment visit and included mental health. In 2019, a Delirium and Cognitive Impairment screening package was released and implemented across Healthscope including training for staff. A distraction box has been developed to support staff in the care and management of patients with delirium or cognitive impairment.

Pre-admission screening is conducted to ensure that any specific risks or needs are identified prior to admission. If this doesn't occur prior to admission, all patients complete the patient health history on admission and includes information on contacts, past history, medication history, social history, cognitive, behavioural, mental health history as well transfusion history. Patient assessments and risks are incorporated into the clinical handover processes. Appropriate prevention plans are put in place for identified risks, for example high falls risk.

Appropriate referrals are made to the multidisciplinary team to assist in comprehensive care planning for every patient. The Comprehensive Care Plan allows for the documentation of goals of care at the time of admission and on a daily basis. The Patient Care Board in each patient room is used as a communication tool including goals of care and any identified risks.

All staff have been enrolled in the Healthscope training package to assist in compliance of identification of Aboriginal and Torres Strait Islander descent patients. The self-identification rate at RPH in 2018 was very low at 0.24%.

The hospital provides information on Advance Care planning and refers patients to Social Workers if they require assistance with the development of their plan. Patients who have an Advance Care plan on admission provide a copy to be included in their medical record and this is identified on the Alert sheet in the health record.

Suggestions for Improvement:

Continue to work on integrating the screening and clinical assessment findings of the different clinical craft groups to further reduce the need for patients and families to repeat information to different clinicians. This will help to ensure that information gained through different clinical assessments is addressed in clinical decision-making and incorporated into the comprehensive care plan. Formalised communication strategies such as multidisciplinary handover and meetings can assist with this as practiced for the oncology patients at RPH.

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:

In 2019, RPH implemented the Comprehensive Care Plan and the Comprehensive Risk Assessment Process. These two documents used together provide a comprehensive source of information to be able to identify risks and develop care plans accordingly for all the staff. Patients and families are involved in care planning throughout admission and involved in decision-making about care and treatment which is demonstrated in the results in the patient experience data. The Comprehensive Care plan allows for the goals of care to be documented at the time of admission and updated during the patients stay as they are discussed and further developed with patients and families.

Monitoring of the effectiveness of the comprehensive care plan occurs by analysis of audit data, incident reports, clinical indicator reports and patient feedback.

Policies, assessment tools and training relevant to the comprehensive care process is available to guide staff. The Nurse Unit Managers have been instrumental in the implementation of the comprehensive care plans during 2019 and they continue to use patient rounding to monitor their effectiveness and support staff.

Healthscope policies and processes are in place to support end-of-life care at RPH. The Healthscope Last Days of Life Toolkit was released in 2019 and includes a number of resources for patients, families and staff in the planning and delivery of end-of-life care. Multidisciplinary team meetings are held with patients and families to discuss plans for care and last days of life wishes. The process of decision-making is iterative and involves assessment and discussion between the treatment team and the patient and families. Patients who are made palliative have physiological observations ceased and commence monitoring for symptoms and comfort. RPH utilises the Healthscope Medical Orders for Life Sustaining Treatment (MOLST) form to record limitations to resuscitation and palliation.

There is access to Cancer Support nurse and a Palliative Care physician to support staff and families during end-of-life care delivery.

Advance Care plans are added to the medical record and noted on the Alerts form when patients provide them during their admission.

There are six designated palliative care beds with sofa beds provided for families wishing to stay overnight. Patients wanting to return home for end-of-life care are referred to Eastern Palliative care who are reported as providing a responsive service.

Staff who are involved in end-of-life care have access to team debriefing in service sessions on self-care and have access to social workers and the Cancer Support nurse.

All deaths at Ringwood Private Hospital are reviewed as part of the quality and risk program. This includes review of MOLST documentation, Advance Care directives and any end-of-life decision conflict.

Any unexpected deaths are referred to the Medical Advisory Committee.

Family feedback is used to review end-of-life care and make improvements in care as well as to encourage staff in the work they do as it is highly valued by patients and their families.

Suggestions for Improvement:

Continue to support the development of the comprehensive care plans and use staff, family and patient feedback to inform improvements and support further innovation in the future.

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:

Risk screening is well established practice at Ringwood Private Hospital and patients identified as at risk have strategies implemented to prevent or minimise the risk of harm. Monitoring care outcomes through incident rates and other clinical indicators is well established and reviewed at the appropriate level quality committee.

For pressure injury prevention the Waterlow pressure injury prevention/treatment risk assessment tool is a part of the comprehensive risk assessment tool which is used to make an assessment of skin integrity on all patients within 8 hours of admission, condition change, weekly and at transfer or discharge. Incidents related to pressure injury are monitored via RiskMan and hospital acquired rates are closely monitored. While the rate was noted as slightly above the national average, there had been no stage 3 or 4 injuries in 2018-2019. Documentation compliance with skin assessment is audited and was 100% compliant in the 2019. Patients and families are provided with information on pressure injury prevention and management and there are opportunities to discuss strategies at the time of rounding and clinical handover.

Equipment and resources were available to staff to prevent and manage pressure injuries.

Falls risk assessment patients are asked about a history of falls and use of gait aids as well as completing the falls risk screening on admission. Twenty-five percent (25%) indicated they had a fall in the last twelve months. RPH had recently participated in a research project comparing the Falls Risk Assessment Tool (FRAT) tool with a new comprehensive care form based on The National Institute for Health and Care Excellence (NICE) clinical guidelines. The outcomes have not yet been released. Strategies are in place for patients identified as at risk of falling and appropriate equipment was available to support these strategies. Falls incidents are recorded in RiskMan and rates are closely monitored and reviewed. While the rate had been above peer rates it has been reducing in the past few years. It was also noted the serious injuries from falls were very low. Falls prevention information and aide's information were incorporated in the Patient Care Boards during the 2019 review and rounding on at-risk patients has been included as an important part of the prevention strategy.

Nutrition and hydration are addressed with support from the dietician and the speech pathologist for at risk patients identified by the malnutrition screening tool. All patient food is prepared on site and special menus and supplements were available.

A cognitive assessment is completed on admission and patients at risk are entered on WebPas and the Alert form. A formalised flowchart assists staff in the process of assessment and prevention and management strategies for patients identifies at risk. The family assists in the development of a specific plan of care around normal routines, likes and dislikes and triggers. In conjunction with the family the TOP5 strategies are developed to help calm and orient the patient. Posters displaying the TOP5 are placed in patient 's rooms as required and are readily available for staff interacting with patients to quickly access information to assist in reassuring the patient, de-escalating behaviours and calming the patient. As well, patients who experience escalation in disruptive behaviour are commenced on a behavioural chart to help monitor and identify triggers.

RPH does not provide mental health services and is attentive to screening patient at pre-admission or admission for a past history of mental health conditions particularly recent admissions. Patients demonstrating suicidal ideation are continuously monitored and not left unattended until transfer is arranged.

RPH also screens for drug use/dependencies and other issues that may precipitate aggression or violence. The Macallister ward provides opportunities for privacy as well as access to lounge areas and outside spaces. An alert system is on WebPas to alert staff to any previous history of aggression and escalation to the GM/DON occurs when a history of aggression is known. Local police have assisted in particular circumstances as there are no security staff on site.

Policies for restrictive practice are in place and strategies to mitigate restraint use are actively pursued. Physical restraint is only permitted as a last resort as demonstrated by a very low rate. Patient seclusion is never practiced.

Suggestions for Improvement:

Review the information provided to families and patients on pressure injury prevention to assist them to better understand and take part in the development of strategies to prevent pressure injuries. While brochures are provided, only 50% of patients recalled this information. It may require a different approach to create opportunities to discuss as well as looking at other ways to get the message across.

While food services are attentive to patient's dietary needs and malnutrition screening occurs routinely, there had been no audit of the food waste returning on patient meal trays. It is suggested this be reviewed/audited to ensure patients are eating the food provided.

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	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

RPH has access to all the Healthscope policies and procedures to support communication for safety. Informal as well as formal processes are a part of the culture in clinical areas and allow the clinical staff to readily communicate and update the clinical team.

A key improvement strategy within Healthscope and RPH Quality and Safety Plan 2018/2019 is the Back to Bedside project. This was implemented in 2018 to support the patient centred care model.

Back to Bedside has three components, reducing rework, ensuring Always Events occur and evaluation of these. The reducing rework projects at RPH included an update of the Patient Care Boards to improve communication and be more focused. The Always Events are around the five key behaviours that patients had reported impact their experience the most. For direct care nurses these were, standard communication, Identification – Situation – Background – Assessment – Recommendation/Response (ISBAR), Patient rounding, bedside handover, Patient Care Boards and acts of kindness. Evaluation of the Always Events is by patient survey.

The overall rating of treatment and care by patients was over 90% for the three months to July 2019. Bedside handover has had a lot of attention, support and encouragement from the Nurse Unit Managers, It was witnessed during the assessment visit and creates a great opportunity for patients and families to check information, provide new details and address goals of care. The Patient Care Boards underwent an extensive review with patient input in 2019. The family escalation of care process and contact number are now displayed on the boards.

Clinical handover incidents are documented in RiskMan, the Incident Management system and clinical handover incidents and their associated impact are recorded and trended over time. This is reported to the Patient Care Review Committee, Quality and Risk management Committee and the Medical Advisory Committee. Risks are identified and recorded from incidents, complaints, sentinel events and changes to legislation or standards.

The risks are reported in the Healthscope Shared Learnings report and are published quarterly so all Healthscope sites can learn from lessons at other facilities.

A new checklist and a time-out process were developed for the administration of chemotherapy and implemented in 2019 following an incident related to chemotherapy administration. This demonstrates how quality improvement strategies address the outcomes of incidents and monitoring activities.

Clinical Handover is practised at all transitions of patient care this includes from the operating theatre to the recovery unit and from recovery to the ward. It was recognised that this could be improved by the review of a Post Anaesthetic Care Unit (PACU) documented discharge criteria to ensure a safe transfer for these patients to the wards and day procedure unit from theatre. This links with Action 8.6 ensuring Ringwood Private has protocols for escalating care.

A discharge envelope was developed in 2019 to ensure all discharge information is provided to patients at the time of discharge. The RPH nursing discharge summaries are completed close to 100% of the time; however, the medical discharge summaries are only completed about 60% of the time and this is an area for improvement.

RPH was able to demonstrate very high levels of compliance with clinical handover in ward areas in 2018-2019.

Suggestions for Improvement:

Support for the Bedside handover needs to continue until the practice is fully embedded and the staff are comfortable to have conversations with patients and their families particularly regarding the documentation of goals. This is well underway and has had a great deal of attention and support during 2019 from management and the NUMs. The Comprehensive Care documentation was implemented in August 2019 and the two processes are complimentary. It will be important to continue the attention and momentum on the bedside handover.

The discharge summary completion rate by the medical staff is an area for attention and improvement and it is suggested a review of the process is undertaken to ensure the summaries are completed at a higher rate.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: While clinical handover occurs between Post Anaesthetic Care Unit (PACU) and the ward and day procedure unit it was not clearly documented what objective discharge criteria was used to ensure a safe transition from theatre to the wards and Day Procedure Unit.
Recommendation:
Review, develop and document a Post Anaesthetic Care Unit (PACU) discharge criteria for patient discharge to the wards and day procedure unit.
Risk Rating:
Low
Risk Comment:
Existing processes exist and no incidents were identified. Current processes are in place to identify patient deterioration and escalation of care.

Correct identification and procedure matching

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

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

Assessment Team Summary:

A comprehensive system is in place for reliable and correct identification of patients when care, medications, therapy and other diagnostic services are provided. This is supported by policies and procedures that require three approved identifiers that ensure the consistent and correct identification of a patient at any time during admission or treatment.

Patient identification and procedure matching is incorporated into structured clinical handover processes with high compliance rates.

RPH monitors compliance to policy on patient identification and procedure matching and communicates any learnings from incidents or near misses through the Health Links Shared Learning Report produced quarterly.

Suggestions for Improvement:

Specialist areas may have specific needs regarding patient identification and this can be the case when patients are attending regularly for care, such as the RPH day oncology unit. It would be useful to review the patient identification and procedure matching in that unit, particularly given the open nature of its environment.

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:

RPH has processes in place to ensure structured, standardised clinical handover is used effectively to communicate about the health care of patients. Clinical handover is conducted each change of nursing shift, first centrally in the ward nursing station, to cover major risks and important information for the group, and then at the patient's bedside which communicates the transfer of a minimum data set including clinical diagnosis, relevant past history, current clinical and risk status, wound status, investigations and their results, needs regarding care as well as discharge planning. The Patient Care Board in the patient's room is updated with the name of the nurse responsible for care and the patient's goals of care for that shift. These boards also highlight specific risks and assistance required by patients and this is reinforced at handover. Patients can opt out of bedside handover and need to give permission for family members to be present.

In 2019 a full relaunch of clinical handover was conducted. This included handover at the bedside with patient and family and the use of ISBAR for clinical communication. These changes were evaluated in September 2019 and demonstrated an improvement is the patient's experience of clinical handover from the May baseline results.

Patient experience surveys indicated they felt members of the care team communicated with each other about the patient's treatment and care.

RPH uses the nursing discharge summary for clinical handover from WebPas for continuity of care to the GP at discharge.

Suggestions for Improvement:

Bedside handover has been relaunched relatively recently and was observed to be running well during the assessment visit. It will be important to continue to support staff to maintain this approach to structured clinical handover incorporating patients and their families whenever possible.

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:

Healthscope By-laws mandate that the admitting VMO is responsible for the care of the patient. If they are not available for any reason, they are expected to secure the agreement of another accredited practitioner who is able and available to provide ongoing care. Staff reported there have been no issues identifying the responsible VMO. ISBAR is used to standardise the communication of clinical information to the VMOs when required.

Clinical deterioration is triggered according to the medical observation charts or by concerns raised by clinical staff or families. These are communicated to VMOs by phone if they are not on site at the time.
While issues relating to surgical patient care are identified during the pre-admission process, there appeared to be no standardised way to communicate these to the relevant anaesthetist. The suggestion was to do this by email; however, not all clinicians seemed to reply to resolve the issue prior to the patient attending for their procedure. An example was provided during assessment where this led to their procedure being cancelled.

Medical orders for resuscitation assist staff to be aware of treatment limitations when appropriate as are end-of-life care wishes and advance care plans.

On admission, patients nominate next of kin (NOK) and contact persons. Any adverse event or clinical deterioration is reported to the patient and NOK in line with the patient's wishes and this is documented in the progress notes.

Patients and their families are encouraged to be involved during the bedside handover and they are encouraged to write on their care boards located at the bedside to ensure patient and clinician interactive communication.

RPH has a family escalation of care policy. Patient Care Boards underwent extensive review in 2019 including the process for family escalation of care if they have concerns about the patients care. Families and patients are also informed that they can press the emergency call bell if required for immediate assistance. The Patient Care Board also informs patients to speak to the Nurse Unit Manager or Nurse in Charge if they have any concerns about their admission or feedback. The contact number for the Nurse in Charge is provided on the Patient Care Board.

Suggestions for Improvement:

It is suggested a standardised approach is developed for the communication of issues identified during the pre-admission screening of patients that require follow up by the anaesthetist who will provide their care. This should include how the information is to be communicated and expected timeframes for follow up.

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	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

RPH is aware that documentation is an essential element of effective communication relating to patient care. There are processes in place to contemporaneously document information in the healthcare record including, critical information, alerts and risks, reassessment processes outcomes and changes to the care plan.

Documentation policies are readily available to the clinical workforce via the Healthscope Intranet and provide information regarding the management of health records. Staff are educated on these relevant policies and procedures during orientation. The Healthscope By-laws documentation instructions are provided to all Visiting Medical Officers at the time of their credentialing.

Documentation Audits are undertaken annually and action plans developed on areas of non-compliance.

Medical records are available in-patient care areas and drop-down boxes are planned to be installed in clinical areas to ensure all information is available at the direct point of care. This will further facilitate contemporaneous documentation and reduce the time required to return to the nurses' station to document care in the progress notes during their shift.

The Comprehensive Care plan is a new document implemented in August 2019 for the documentation of the comprehensive care and patient goals. The plan is completed on admission and updated every shift.

There are always opportunities for improvement and documentation was identified in this criterion that could be reviewed for improvement. The CARE elements provide a useful guide when considering what best practice documentation looks like. Medical record documentation should be compliant and complete, accessible and accurate, readable and enduring.

Suggestions for Improvement:

While the documentation of clinical information meets the requirements of this criteria a recommendation is made to look at best practice clinical documentation as a future piece of work for RPH.

This is made to ensure in the future the medical record meets the patient care needs and assists the staff to even better deliver comprehensive care. The medical record should be accessible and accurate.

This will be assisted by the introduction of the drop-down boxes planned to be implemented in the ward areas soon.

Patient care requires relevant information to be readily at hand, easy to locate and information recorded should reflect all the events being documented.

The documentation should be readable, acronyms and abbreviations should be avoided if there is any potential for ambiguity, and documents should be as specific as possible.

The record should be enduring so the meaning of the documents is maintained and they are completed in such a way that someone who is not present at the time of the recording can interpret the information in the future. This can be assisted with standardised templates developed with clinicians to support documentation.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: There is an opportunity for improvement in medical record documentation as described in the assessor suggestions.
Recommendation:
RPH review best practice medical record documentation to ensure accurate statements of clinical interactions between the patient and treating doctor relate to assessment and diagnosis, care planning and treatment. Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient to provide ongoing care at any time.
Risk Rating:
Low
Risk Comment:
The current documentation meets requirements of this criteria to support patient care but it has been identified there is an opportunity for improvement to better support patient comprehensive care.

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:

Healthscope and RPH demonstrate appropriate governance, leadership and commitment to ensure safe and high-quality care of patients own blood and to ensure blood product requirements are met. This standard is being well addressed and met. Healthscope has a range of policies and procedures that are consistent with national evidence-based guidelines for the management of blood and blood products.

All staff who participate in the process of blood or blood product transfusions are required to have satisfactorily completed a mandatory National Blood authority "Blood Safe" training. At the time of assessment this was completed by 100% of the current nursing staff.

Healthscope has a corporate transfusion committee and Ringwood has representation on this group. This group undertake at least two quality improvement projects a year as well as developing and implementing best practice policies and procedures when required. There is a suite of audits relating to blood and blood products undertaken regularly. In addition to these, RPH reviews the validation certificates to ensure cold chain is maintained, audit the blood register to check documentation compliance and ascertain wastage, reviews any incidents monthly and monitors the completion of training for all nursing staff.

National Healthscope KPIs are collected relating to blood and blood products and are discussed at the Quality and Safety Committee and any other relevant committee. RPH also submits to the ACHS clinical indicators relating to this standard. The blood appropriateness audit in August 2019 demonstrated good compliance with best practice transfusion principles and guidelines.

Due to the patient cohort and volume of blood administered per month (70 to 100 units) at RPH a decision was made to have all staff complete their Blood Safe annually.

Many improvements have been implemented to support the management of blood and blood products at RHP. These include improved patient consent rate, patients attending the ward for transfusions rather than day oncology, development of a patient discharge information sheet on post-discharge management following a transfusion and better management of the blood fridge and its room environment.

Patients are provided with the SA blood transfusion information brochure which was reviewed and approved by the Consumer Consultant.

Suggestions for Improvement:

Given the volume of blood being transfused at RPH and the cohort of patients, it will be important to continue to be attentive to all aspects of blood management and ensure any incident or near miss is analysed and adjustments made to processes if required.

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:

RPH ensures clinical staff are aware and compliant with the relevant policies relating to use and management of blood and blood products.

Pre-admission clinic pre-admits and screens all surgical patients and this includes transfusion history, anaemia and any medications that will impact on clotting profile. Information is provided on how and when to cease relevant medications prior to their surgery according to their procedure and impact on their medical condition. Any concerns about blood management are escalated to the surgeon or anaesthetist.

Patients undergoing chemotherapy treatment have their haemoglobin levels monitored by their oncologist who orders blood according to their laboratory results and patient symptoms. Because the oncology patients have so much blood taken for pathology, a recent audit was undertaken for Blood Matters Victoria regarding blood sample volume and the iatrogenic anaemia that it can cause. ACHS Clinical Indicator 6.3 which monitors the appropriateness of transfusion demonstrates RPH is within the aggregate range for transfusions where the Hb level is > than 100g/l. Transfusion indications were documented by the medical consultant in 95% of medical records audited in 2019.

RPH staff involved in transfusion processes complete mandatory training Blood Safe eLearning. During 2018/2019 there were no incidents related to adverse reactions to blood or blood products. Any new adverse reaction would be documented on the alert form in the medical record.

Healthscope has developed the Blood and Blood product prescription and transfusion record form which includes a checklist for staff to complete prior to transfusion and includes space for the patient's transfusion history.

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:

Strategies are used at RPH to effectively manage the availability and safety of blood and blood products. The transfusion pathway audit demonstrates compliance with many areas of risk in administering blood and blood products. The audit covers collection from the blood fridge, bedside checks and the transfusion checklist documentation. Overall compliance with audit was 97% in 2019. Cold Chain is monitored on delivery of products with a validation certificate from Dorevitch Pathology. This is closely monitored by RPH. The blood fridge is maintained by Clinical Labs and compliance with daily checks was 97% and on all occasions the temperature was in acceptable range. The most recent audit (June to August) demonstrated only 1% of units were returned to the fridge. There was no breach in cold chain or wastage of these units.

Documentation of transfusion details in the patient's medical record allows traceability of blood products, investigation, analysis, evaluation and improvement in clinical outcomes and clinical practice.

The number of blood related incidents are low (0-3 per month) and mostly relate to management issues rather than administration. The cross match to transfusion ratio is 1.03. Blood wastage is 1%. All O-ve blood was returned before expiry.

There are 2 units of O-ve blood kept on site for emergency use but all other blood is ordered for individual patients when required. Group and holds are requested by VMOs at pre-admission or on admission but blood products are only dispensed by the provider as required. The turnaround time on availability for blood cross matching was reported by RPH to be less than 2 hours from a new sample.

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:

RPH is very aware of the importance of the intent of this standard and is attentive to clinical observations and their documentation, processes to recognise deterioration and staff training to ensure it is clear what triggers a response for a patient who is deteriorating. RPH has an annual Safety and Quality Plan which includes Recognising and Responding to acute deterioration and has local policies that provide guidance in the event of clinical deterioration. These are reviewed by the clinical working parties and endorsed by the Patient Care Review Committee and the General Manager.

RPH also has a suite of Healthscope policies that inform and support recognising and responding to acute deterioration.

There is a clear process for family and patient escalation of care and a local policy supports this. The process is outlined on the Patient Care Boards located in each patient room.

RPH has a three-tiered rapid response system escalating from clinical review by a senior staff member to a Medical Emergency Team (MET) response and finally a Code Blue response.

RPH records all MET calls and Code Blues in RiskMan and these are reviewed monthly by the Quality Manager and any issues or trends are reported to the General Manager, Quality and Risk Management Committee and the Medical Advisory Committee. All deaths are reviewed and 97% of patients had a clear limitation of treatment document (MOLST) in their medical record and 93% were documented as palliative.

Data on all rapid response system calls are collected and submitted for comparison with peer Healthscope hospitals. Reports demonstrated RPH has a higher than peer rate of rapid response calls with the twelve months average sitting at 6% per bed days with the national rate closer to 4%. In the same time period, there were no Code Blue calls at RPH. It was felt this indicated patients who are deteriorating are identified early and managed or transferred to a higher care level for ongoing management.

A training needs analysis from 2019 indicated 100% of staff felt confident in the identification of the deteriorating patient both physically and mentally/cognitively. Ninety-seven percent (97%) of staff indicated they were aware of the rapid response system in place.

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:

RPH has policies that clearly outline the use of vital sign monitoring, documentation and the detection of clinical deterioration. These are readily accessed via the IT platform.

RPH uses track and trigger tools that are evidence based and audits for compliance are undertaken and action taken if compliance is less than 90%. Monitoring of the observation charts occurs at the bed side in association with the patients care plan. The care plan documents the monitoring and observations required for individual patients.

Patients are screened on admission for past and relevant history of mental health, delirium or risk of self-harm. Risk assessments and management strategies are in place for concern relating to mental health, delirium and cognitive impairment. Staff can escalate care at any stage even when physiological observations do not meet escalation criteria, this includes deterioration in the patient's mental state.

Overall, RPH has low rates of patients experiencing delirium with a low HAC rate relative to peers. Many improvements have been introduced for recognition and management of deterioration in mental health including, the introduction of the cognitive screening tool, the introduction of TOP5, the process of including families in management plans, monitoring incidents through RiskMan, benchmarking using HAC data, development of policies and the implementation of behavioural management plans.

There is an opportunity to ensure patients transferring from PACU to the ward have clearly established discharge criteria to ensure the correct parameters are reviewed to prevent the possibility of deterioration not being recognised and appropriate intervention being delayed. This is covered in Action 6.4 under handover.

All MET calls are reviewed and of the 74 MET calls from Oct 2018 to June 2019 it was noted 10 had previous observations in the escalation zone and were not initially escalated. These incidents are followed up and used as a learning opportunity for improvement.

Suggestions for Improvement:

Continue to reinforce the importance of using the track and trigger observation charts and escalating care when patients have parameters in the escalation zone.

Ensure patients and families feel comfortable to escalate care. There is a very clear process for them to do this but the rate of them utilising it is very low.

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	
Met with Recommendations	All facilities under membership
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:

Healthscope has a suite of policies that govern the required skills for management of episodes of acute deterioration by staff. RPH has a 24-hour rapid response system for both MET and Code Blue calls. The team is primarily senior nursing staff based with support services to assist. Medical Officers, usually VMOs, on site at the time of an emergency call may attend and assist. The patients admitting doctor is contacted for phone orders and to initiate discussion about transfer to another facility if more complex or intensive care is required. There was no documentation available to review the compliance of the Medical Officers BLS training.

The MICA ambulance is called if required for advanced life support. The nearest ambulance station is 400 metres from the hospital and on all occasions has attended when requested with no delay. A public hospital is less than a kilometre away and has a funded Emergency Department, Mental Health Service and Intensive Care unit. Patients can also be transferred to Knox Private Hospital, a sister Healthscope facility, which also has an Emergency Department and Intensive Care unit. Paediatric patients are managed by PIPER who support advanced life support for paediatric patients and transfer to an appropriate paediatric facility.

RPH nursing staff undertake annual mandatory training in Basic Life Support (BLS) both online and practical assessments, Adult, Paediatric and Neonatal.

Considerable work had been undertaken to ensure a safe environment and monitoring of paediatric patients with a splitting of the response and escalation from adult patients, PIPER training and attention to the environment paediatric patients would be cared for in. This was to ensure processes were in place for the small number of paediatric patients admitted to the inpatient areas each year.

Responsibility for compliance with mandatory training rests with Department Heads and this is assisted by the provision of reports monthly on those up-to-date with training. Trained trainers are used as champions in ward areas to ensure all staff complete their training annually and are competent to practice. At the time of the assessment, BLS was 100% for theory and practical for all nursing staff.

Adult and Paediatric observation charts have built in escalation processes to allow for recognition and escalation of identified deterioration. Clinical indicator reports demonstrated consistently high compliance with response times. Reviewing the peer group comparison there had been no Code Blue calls since 2017.

Suggestions for Improvement:

Continue the focus on the mandatory training compliance rates for the VMOs in accordance with the Commissions Advisory.

The attention and monitoring on paediatric trigger and escalation processes to continue.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Although the medical officers may attend and assist at a rapid response call, their compliance with BLS mandatory training was not recorded by RPH.
Recommendation:
The BLS/CPR training status of the Medical Officers to be recorded by RPH according to the Commissions Advisory relating to this.
Risk Rating:
Low
Risk Comment:
Most of the Visiting Medical Officers, but not all, have an appointment at a public hospital where it is mandatory to complete BLS training.

Recommendation from Current Assessment

Standard 6

Organisation: All facilities under membership
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

Recommendation:
Review, develop and document a Post Anaesthetic Care Unit (PACU) discharge criteria for patient discharge to the wards and day procedure unit.

Organisation: All facilities under membership
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

Recommendation:
RPH review best practice medical record documentation to ensure accurate statements of clinical interactions between the patient and treating doctor relate to assessment and diagnosis, care planning and treatment. Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient to provide ongoing care at any time.

Standard 8

Organisation: All facilities under membership
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

Recommendation:
The BLS/CPR training status of the Medical Officers to be recorded by RPH according to the Commissions Advisory relating to this.

Rating Summary

Ringwood Private Hospital

Health Service Facility ID: 101103

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 with Recommendation

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 with Recommendation

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 with Recommendation
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Nil