NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Northern Beaches Hospital

Frenchs Forest, NSW

Organisation Code: 126924
Health Service Organisation ID: B2020049
Assessment Date: 11/11/2019 to 15/11/2019

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

Northern Beaches Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 11/11/2019 to 15/11/2019. The NS2 OWA required 6 assessors for a period of 5 day(s). Northern Beaches Hospital is a private organisation, also providing public services. It was last assessed between 07/11/2018 and 09/11/2018 (Interim Accreditation). Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Northern Beaches Private Hospital	R100017
Northern Beaches Public Hospital	R100017

General Discussion

Northern Beaches Hospital (NBH) provides an extensive range of clinical services to public and private patients under the partnership Project Deed agreement with Healthscope, being the Operator, and the NSW Government.

Lead by a dedicated and committed executive team it was evident care and services are delivered safely.

The assessors extend thanks to the executive, the quality team, department managers, clinical and support staff, medical staff, pharmacists 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 all National Safety and Quality Health Service (NSQHS) Standards 2nd edition being rated Met.

Significant progress has been achieved in relation to compliance with the current ACSQHC's Advisories which have all been met and where a gap analysis and action plan is required, they have been completed and remain ongoing.

The assessors were impressed with the seamless integration of services which was clearly evident when visiting the clinical and support departments as well as Medical Imaging, Pharmacy and Pathology.

The Outpatient Clinics are extremely well managed providing patients with timely access to Consultants, which includes new referrals and follow up appointments, Allied Health services and nurse lead services such as midwifery. The Day Oncology and Renal Dialysis Services and the Transit Lounge are impressive, providing timely care and services in dedicated well designed departments

The GP Medical Centre, adjacent to the Emergency Department (ED) also provides timely support to the ED in assisting with the triaging of category 4 and 5 patients reducing the waiting times for patients to be seen. The Centre has also been involved in staff health for example, providing immunisations to staff as requested.

NBH demonstrates a culture of quality and safety across the hospital through their integrated governance system that actively supports and manages patient safety, quality and risks. Continuing

to initiate and be responsive to improving safety and quality of patient care services is of paramount importance. Processes of reporting, auditing, review and critical analysis and reflection were evident.

Healthscope Corporate services in collaboration with the clusters and Healthcare Infection Control Management Resources (HICMR) Infection Control Consultants oversee and provide a raft of evidence-based clinical policies and guidelines available on the Healthscope Intranet (HINT) and dedicated portals to support clinicians and staff at the point of care.

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

The patient electronic medical record (eMR) is well integrated and appropriate to good patient care. Further enhancements are occurring regarding the uploading of the existing hard copy medical record forms into the electronic platform. There has been a Met with Recommendation rating for action 1.16 to develop an IM&T road-map to identify priorities and evaluate progress.

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

Performance and skills management has established systems in place to support, monitor and evaluate performance across all disciplines. The Education Centre provides extensive simulation scenarios which are well received by the clinical workforce. Staff education and training in respect of patient safety and quality is comprehensive.

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

Patient 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. The Consumer Consultants are also involved in all levels of governance and provide feedback on patient information and review the patient experience survey results.

The assessment team acknowledges the Volunteer workforce for their dedication and commitment to patients' families and visitors when entering the hospital and for providing help and support as needed.

Preventing and Controlling Healthcare Associated Infections is evident in all clinical units and support services. The new hospital is beautiful, spacious and conducive to good patient choices in regard to infection control isolation and care. The Infection Control Committee is to be acknowledged for their monitoring of infection control systems across the hospital. The low infection rate is testament to the efficacy of the systems in place.

The Antimicrobial Stewardship Program is well established and is clearly understood by all clinicians. Improvements have been made in relation to prescribing and the antibiotic formulary.

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. The engagement of the clinical pharmacists is highly regarded and a benefit to the clinical departments service.

Comprehensive Care strategies and procedures are in place to provide continuous and collaborative care. The Comprehensive Care Plan has addressed key care criteria and audits are in place to identify areas for improvement. Consumers are well engaged in decision-making and providing feedback; this includes screening and assessment, identifying goals of care and care plans for identifying patients at end of life.

Systems in place to minimise patient harm was evident. There are well documented policies and procedures as well as risk assessments in place for the management of pressure injuries, falls prevention and nutrition and hydration.

There has been significant work conducted by NBH and the Mental Health Unit in collaboration with clinical staff and external providers to ensure there are systems and processes in place to recognise, prevent and manage delirium, cognitive impairment, self-harm and suicide, violence and aggression, as well as restrictive practice, restraint and seclusion. NBH has developed a comprehensive audit system and audit calendar schedule that will assess compliance against these criteria.

It was also noted by the assessment team when visiting departments, that the staff had a good understanding of the importance of recognising and managing mental health issues and the procedures and clinical support readily available. This education and training also included support staff.

NBH is also commended on their self-assessment and mapping of the National Standards for Mental Health Services to the NSQHS Standards 2nd edition. This independent assessment was agreed to be conducted at the time of the Organisation-Wide Assessment and is submitted as a separate report. All standards were met; however, there are some suggestions in the body of the report identifying areas for improvement.

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

Clinical Handover is supported by good local processes, which were developed in collaboration with clinical staff, patients and carers. The information provided and communicated to staff on the "Huddle Boards" and patient whiteboards is impressive.

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

Skilled, caring and responsive staff are educated in recognising and responding to clinical deterioration with good systems to escalate unexpected deterioration in a patient or paediatric patients health status. Events are diligently monitored and reported.

It was evident, at the time of the assessment, the executive and staff's commitment and tireless efforts in providing patient-centred care to patients, carers and families.

NBH should be proud of their ongoing commitment and dedication in improving care and services in their first year of operation.

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

Summary of Results

At Northern Beaches Hospital's Organisation-Wide Assessment 1 Action(s) were rated Met with Recommendation across 8 Standards. The following table identifies the Action(s) 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
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. **Recommendation:** NBH develop an organisational IM&T strategic plan and road map for rolling out its digital systems and clinical and business intelligence platform.	All Facilities under membership

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

Northern Beaches Hospital

Sites for Assessment

Sites for Assessment - Northern Beaches Hospital

Northern Beaches Private Hospital HSF ID:R100017	
Address: 105 Frenchs Forest Road (West) FRENCHS FOREST NSW 2086	Visited: Yes

Northern Beaches Public Hospital HSF ID:R100017	
Address: 105 Frenchs Forest Road (West) FRENCHS FOREST NSW 2086	Visited: Yes

Northern Beaches 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:

Healthscope has organisational Board governance and leadership of NBH. There are four governance pillars that include Quality Clinical Outcomes and Exceptional Care, which have been integrated into NBH culture through a recent two-day workshop with senior staff. Healthscope has a strategic plan setting future direction and goals; and NBH has developed a local Clinical Governance Safety & Quality plan with actions reporting up to Healthscope. NBH has a clear organisational structure led by the CEO and a Committee Structure that has the Executive Committee providing overall governance at NBH and reporting directly to the Healthscope Board. Healthscope has a comprehensive suite of policies to ensure that NBH maintain a culture of safety and quality.

Healthscope has a Consumer Engagement Plan that details strategies on engaging with consumers at all levels; as well as a comprehensive list of policies providing clear governance on partnering with consumers. NBH has well established consumer consultants who are provided with appropriate orientation and training to be able to represent consumers at the most senior clinical governance committee - the Patient Care Review Committee. The patient survey feedback system is well established now and drives further improvements.

NBH has a Clinical Governance Safety & Quality Plan, aligned to Healthscope and their Governance Framework, which ensures that there is member of the Executive leading all NBH Committees. The Executive Committee has four key areas that is the focus of their weekly meetings; with one being Quality, Risk & Clinical Operations. The NBH Clinical Governance Framework's processes have been endorsed by the Healthscope Board and there is evidence of a strong focus on the criteria in Standard 1 Clinical Governance Standard in the 2nd edition of NSQHS Standards.

The NBH workforce understands its safety and quality responsibilities and the orientation program and mandatory training program (ELMO) is in place to ensure that staff are aware of their responsibilities in relation to safety and quality. Healthscope policies direct the correct management of all clinical incidents and near misses; and is wholly adopted by NBH. Incidents and near misses are recorded on the RiskMan incident reporting system and reviewed by the Line Manager, Quality team and WHS Manager. All SAC 1 and 2 incidents are automatically escalated to the senior Executive. Serious incidents and sentinel events will be firstly discussed at the weekly (soon to be fortnightly) multidisciplinary Critical Incident Review Committee (CIRC) and then escalated if required to the monthly Patient Care Review Committee (PCRC), which has a consumer consultant representative.

NBH reports Clinical Quality KPIs to Healthscope on a quarterly basis for review by the National Hospital Quality Committee. All non-conforming incidents have an action plan developed. The overarching Healthscope Quality and Safety Report is tabled at the monthly NBH PCRC meeting and includes Hospital Acquired Complications (HAC) with clear control measures discussed and documented. Healthscope has developed a Reconciliation Action Plan (RAP) and they have established a committee to progress the requirements of NSQHS Standards (second edition). NBH held a local launch of the RAP during NAIDOC week (June 2019). The NBH RAP working party is working on local indigenous strategies for improvements in safety and quality. It was evident that the NBH Executive and senior committees regularly review specific NSW Health and Northern Sydney Local Health District (NSLHD) KPIs on Aboriginal and Torres Strait Islander (ATSI) patients, which include workforce data, patient experience and complaint data. This safety culture is reinforced by the very proactive Aboriginal Consumer Consultant who is contributing to work in the safety and quality area.

The Healthscope Board operate under a Board Charter and have endorsed the organisational code of conduct for all staff. The Healthscope Quality & Risk plan leads the discussion on ensuring that safety and quality in healthcare is considered a priority at all levels. The Executive team ensure that NBH systems and processes meet the requirements of the eight NSQHS Standards with Executive sponsorship. The assessors evidenced a high degree of teamwork amongst the new Executive members and their planning of the integration of current and new services to be provided for NBH patients, carers and clinicians.

Both Healthscope and NBH have processes aimed at meeting the specific needs of Aboriginal and Torres Strait Island people. While there is a very low number of patients self-identifying as Aboriginal and Torres Strait Islander people, only 0.5% at NBH compared to 0.6% in the Northern Beaches LGA; NBH ask all patients if they identify as an Aboriginal or Torres Strait Islander. A recent improvement at NBH included specific training for front line staff to support them in feeling comfortable asking the question. Reports are provided to the NBH Executive on all data relating to Aboriginal and Torres Strait Islander people.

The Healthscope Quality & Safety plan sets the direction to ensure that safety and quality is included in all business decision-making and this is demonstrated in the NBH Safety & Quality plan. The Safety & Quality Framework clearly articulates the three key categories of maintaining safe and effective care as: 1) Monitoring, 2) Reducing Risk and 3) Continuous Improvement. The assessors noted that the Executive committee meeting minutes demonstrated that the quality and safety of the health care is considered in all business decision-making and that all significant strategic, quality and safety and financial concerns are escalated to Healthscope.

The NBH staff are aware of their safety and quality responsibilities, as evidenced by Position Descriptions, contracts, Letters of Offer, the orientation program and local induction processes. The VMOs are informed of their responsibilities through the NBH credentialing process and are required to adhere to the Healthscope By-laws 2018. The orientation program and mandatory training program (through ELMO) is in place to ensure that staff are aware of their responsibilities in relation to safety and quality. The assessors noted that the staff annual performance reviews were up-to-date across the wards and departments. There is a comprehensive mandatory training program, with high compliance rates noted across all areas. Oversight of compliance is regularly reported and where less than optimal compliance is noted, appropriate action is taken.

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	
Met with Recommendations	All facilities under membership
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:

Healthscope has a comprehensive suite of policy documents, utilised by NBH that are prepared and distributed by the Healthscope Corporate Document Controller (CDC) for local use. These policies and procedures are readily available on HINT for those staff who need to use them. NBH also adheres to applicable NSW policies and in the last 12 months have been able to develop a suite of local NBH policies. The Healthscope policy review process is initiated by the CDC, who receives feedback on policies and then sends the feedback on for consideration by the policy author.

NBH has appointed a dedicated Policy Project Manager who is responsible for coordinating the NBH policy register, review of policies, distribution of updated Healthscope and NBH policies and monitoring for changes in local legislation that may affect the policy. Healthscope has a Policy Monitoring Compliance policy, adopted by NBH, to ensure that compliance to policies is monitored, either through the annual audit schedule or through reviewing near misses and incidents against policy. There are specific NBH policies for higher risk clinical procedures and these are monitored more frequently for compliance.

NBH established a Policy Development Project, with an Executive sponsor, to review existing policies to ensure organisational needs are met. So far 75% of high-risk policies initially deemed high risk have been published, and over the last 12 months NBH has reviewed and published 196 local policies. A recent policy survey of staff found that 97% of staff knew how to access policies and 96% received policy updates from their Managers. Staff are also provided with updates in the staff newsletter, in the policy and procedure section, which provides information and a summary of policy and procedure updates.

The NBH Safety & Quality plan identifies the measures to be used to monitor performance and to disseminate quality data. Both Healthscope and NBH have a well-established audit schedule that aligns with the Governance Framework. There is a schedule of audits that is aligned with the eight National Standards and which includes both clinical and non-clinical areas. Performance monitoring includes core Healthscope KPIs, as well as NBH NSW Health KPIs. NBH reports their performance and clinical outcomes publicly online; so that comparisons to national benchmarks are clearly seen by the public.

The NBH Safety & Quality plan and Governance Framework are adapted from Australian Commission on Safety and Quality in Health Care (ACSQHC) and provide the framework for safety and quality monitoring, review, risk management and improvement quality initiatives. NBH is included in Healthscope's Quality Management System and is required to identify areas of improvement utilising Healthscope systems. Some examples of improvements are the `Perform' leadership project, eMeds project, Falls Prevention project and clinical escalation response system design. Departmental quality improvement projects include PPH management, consumer involved handover in mental health and the `My Card' ED communication tool. Audits of hand hygiene and red blood cell wastage resulted in specific quality improvements strategies.

The NBH Committee Structure supports the monitoring and evaluation of improvement projects. For example, clinical committees reporting to the PCRC will provide quality improvement updates using a standard reporting template. The Healthscope shared learnings report is reviewed by NBH and relevant learnings implemented locally. NBH has consumers embedded into the most senior safety and quality meetings including representatives on PCRC, Medication Safety, Infection Control, Falls working group and the Minimising Patient Harm Committee.

The monthly Healthscope Quality and Safety Report is presented at all levels of governance, including to the Healthscope Board, Senior Leadership Team, all GMs and DONs, Quality Managers and Health Information Managers. The comprehensive quality KPI report incorporates reports from RiskMan, core indicators, ACHS clinical indicators, core hospital-based outcome measures, clinical KPIs, sentinel events and patient feedback.

Staff are encouraged to access the Quality KPI and Patient Experience data on HINT and department managers also report ward specific data to their staff. There are also staff forums, newsletters, quality boards and regular email information updates. Healthscope is very transparent in its reporting on quality and safety to consumers and utilises the MyHealthscope website for patients and consumers to see timely benchmarked outcomes. Consumers are also actively involved in reviewing patient feedback and quality data and also advising on quality improvement projects. NBH has developed a close working relationship (partnership) with NSLHD and NSW Health and provides monthly safety and quality reports which are reviewed at the joint operational service group meeting.

NBH has an integrated Risk Register on RiskMan, which is now well established and overseen by relevant committees, including the Executive Committee. RiskMan is used to ensure a comprehensive collection and classification of risk rated data, which is available to the relevant committees. The local NBH risk register is aligned with the Healthscope risk register and is used to monitor and reduce the level of risk at the local level. All risks have a clearly identified owner and the tracking of risks is transparent. The Executive authorise all new risks, which are identified through data gathered from many sources including incidents, complaints, national shared learnings, coronial cases, M&M meetings, PCRC and Audits. NBH are 100% compliant with the Healthscope KPI for risk register review.

All new risks and any risk upgraded to `high' must be tabled with the NBH Executive and reviewed within 1 to 3 months. A recent example of improvement includes perineal lacerations, which were higher than the national rate and now with a working group focusing on education and training, is now trending below the national rate.

Healthscope are currently reviewing the RiskMan system and are currently consulting with key user groups nationally. NBH is leading the way in becoming the only Healthscope hospital to apply the SAC rating to all incidents, in line with the reporting requirements of NSW health. The colour coded heat map in the risk register clearly identifies those risks with a high severity and likelihood and then provides a comparative risk once control measures are implemented. However, the assessors noted that the risk register is very comprehensive and complex and that some changes could be made so the Executive can clearly see and focus on the NBH top 10 risks.

Discussion between the assessors and staff confirmed that there was a clear awareness of the risks recorded in RiskMan, with active work underway in relation to the top organisation risks. Within individual departments there was also an awareness of the need to identify safe working practices and to take appropriate action.

Suggestions for Improvement:

The current NBH risk register is very comprehensive but is difficult for the Executive to closely monitor and close out risks with good control measures. It is suggested that NBH review the risk register to focus on the top 10 clinical risks, with an Executive clinical lead made responsible for the sentinel event action plans. A `traffic light' model would ensure that the Executive focus their attention to moving the top 10 risks from red to green.

Healthscope mandates minimum requirements for facility disaster planning through the Disaster Management and Recovery Plan policy. NBH has an Emergency Management Plan, Business Continuity Plan and Chemical Biological Radiological Plan. NBH is represented on the NSLHD counter disaster committee and have had the required disaster training and desktop exercises. NBH has recently rolled out a comprehensive Code Brown plan which involved a new resource folder and education and training of all Managers and staff. The hospital switchboard has been upgraded and now includes a fire panel. The assessors witnessed the NBH disaster team in action managing the bushfire situation and assisting with the evacuation of Lady Davidson Hospital.

Healthscope has a comprehensive suite of policies and procedures to support the workforce recognise and report incidents on RiskMan. NBH has added a local policy on incident reporting to NSW Health. All staff are trained on RiskMan at orientation and on an ongoing basis and are aware of reporting all near misses. Patients, carers and families will find information on reporting their concerns through the rights and responsibilities leaflet, mental health information packs, patient information directory, NBH and Healthscope websites, through the patient boards in each room and using the patient feedback platform. NBH recently rolled out Recognise, Engage, Act, Call & Help (REACH) as a communication tool to escalate a clinical concern.

Healthscope policies and procedures guide staff on incident management and appropriate training is provided at a department level. Staff enter incidents which are then reviewed by their line manager or

escalated immediately depending on the Safety Assessment Code (SAC). Staff are also involved in clinical incident reviews and sentinel events are reported to CIRC and PCRC. Daily huddles are conducted on all wards involved in PERFORM, where adverse incident reviews are discussed with staff to identify possible immediate local control measures.

NBH utilises information from their incident management and investigation system to improve safety and quality; and also acquires external information from Healthscope shared learnings, staff involvement in RCA/CSR completions and policy review following incidents. Improvements include mental health bathroom adjustments and clinical handover. Incident data is trended within the Quality & Risk Management Framework and risk escalated through the NBH Committee structure. The CIRC committee, a sub-committee of PCRC, was established when NBH opened and has been meeting weekly to review serious incidents and near misses. This Committee is instrumental in managing critical incidents.

NBH utilises the Healthscope Open Disclosure policy. The principles of open disclosure are in use at NBH and captured on RiskMan. Open disclosure training (through ELMO) is provided to all clinical managers and staff and reporting is included in the Executive Committee report and Board reports for appropriate action. The NBH patient experience results show a gradual increase in patient's disclosing an experience of harm. All patient experience results are followed up with the Quality Department and reported at the PCRC.

NBH is included in the patient-centred care program, which is now called 'Back to Bedside' and focuses on 'always events' such as communication, rounding, handover, patient care boards and acts of kindness. Patients are then sent an online survey after discharge to seek their feedback on their experience and outcome. The feedback can also be obtained via phone or on forms. Staff feedback can include debriefing following an incident, staff forums and department meetings. Recently an organisation wide employee engagement survey was conducted, with a 40% response rate, which has now resulted in an action plan to address the concerns raised by staff. Serious complaints will have action plans developed and both complaints and compliments are registered on RiskMan, then reported to PCRC.

Complaints are well managed as per the Healthscope Complaints Management policy and procedure. Information for patients on how to make a complaint is readily available at bookings, the patient information directory and waiting areas. Patients can also submit a complaint in person, by phone or by completing a feedback form. Complaint response times, severity and outcomes are monitored through RiskMan by the Quality or Executive team. Incidents and complaints management are supported by staff training sessions on Risk Management and RiskMan during orientation and mandatory training. The information from RiskMan and the Risk Register are managed locally. Interviews with staff confirmed an awareness of their responsibilities in reporting risk and knowledge of using RiskMan.

All complaints are investigated as per the policy and procedure, logged on RiskMan and managed actively as per the policy. Acknowledgement to the complainant is provided within two working days and a response within 35 days. Since January 2019, NBH has met these response KPIs. The assessors also noted that the number of complaints has been steadily falling over the last 12 months. Complaints and feedback are used to identify areas for improvement and these improvements are reported to PCRC, Department meetings, staff huddles and staff forums. Complaints incorporated into the risk register include poor visibility of pedestrian crossings in the car park and the colour (visibility) of the ED bollards.

Healthscope policies on Diversity and Inclusion and Gender Identity are utilised by NBH; however, they have also created local NBH policies on culturally and linguistically diverse (CALD) populations, Interpreter Services and Pastoral Care Services. NBH review its diversity and service profile annually and publishes the data in the annual report. Current data shows the majority or patients self-reporting as Australian, with ATSI at 0.58%, UK 8.46%, NZ 2.50%, Italy 2.07%, Philippines 1.40%, Croatia 1.06% and China 1.02%.

Of this, 94.32% self-report speaking English, but when English is a patient's second language, translation and interpreter services are readily available if needed. The use of these services is monitored and reported, with low activity noted. NBH monitor at-risk groups seeking health care, with a focus on Aboriginal people who re-present to ED within 24 hours and women with an aboriginal baby receiving antenatal care prior to 14 weeks gestation.

There are a number of Healthscope and NBH policies designed to identify patients who are at a higher risk of harm e.g. mental health patients for self-harm, the elderly for falls and also Aboriginal patients. All relevant staff are provided with Cultural and Aboriginal and Torres Strait Islander training and evidence of attendance rates was noted.

All NBH clinicians have access to accurate and integrated healthcare records via the eMR, and the Health Information Exchange (HIE) which is available to all NSLHD facilities, and HealthyNet NSW wide. The HIE is a recent addition and provides an excellent view of all key aspects of patient records across the District. Implementation of this system has considerably improved immediate access to historical patient information at the point of care. There are extensive computers and workstations on wheels available for staff throughout the facility.

The eMR has had an interesting and complex journey from the outset; however, a commendable effort has been expended to ensure the system is safe for patient care. Initial issues with functionality and training have been and continue to be addressed, with frequent upgrades, improved training and support, and increased availability of forms, templates and system functionality.

All actions have been Met for Action 1.16. However, whilst there is an overall IM&T Project Plan in place there is a recommendation to develop of an IM&T strategic plan for mapping improvements and priorities in relation to the future roll-out of the eMR.

Training for the eMR system is conducted at orientation, and online instructional resources are available on the intranet. Due to the numerous and frequent system enhancements, it is important to ensure these resources are updated each time system changes occur. Appropriate privacy and confidentiality mechanisms are in place, including processes for management of breaches of access to records. Audit of patient record documentation occurs in relation to specific forms, care plans and pathways.

All patient information is shared within the NSLHD via the HIE. All discharge summaries are automatically uploaded to the My Health Record System and are sent electronically to referring doctors. Discharge summary completion rates are audited and reported to Executive monthly. Duplicate registrations are identified and managed via a weekly report generated by NSLHD, or via local reporting of individual cases. Merging of records occurs after patient discharge.

Although a corporate policy around My Health Record (MHR) exists, no specific training of the clinical workforce has occurred to date. At present MHR is not accessible via HIE or eMR, so the risk of access breaches by clinical staff is low. A gap analysis has been conducted in compliance with Advisory AS18/11.

Suggestions for Improvement:

Appropriate privacy and confidentiality mechanisms are in place, including processes for management of breaches of access to records. However local capacity within the Health Information Service for routine reporting of potential breaches would ensure timely and responsive identification and management. Although some audit of localised patient record documentation occurs, there has been no general documentation audit of eMR content and quality. As existing Healthscope documentation tools are not applicable to digital records, consideration should be given to appropriate and beneficial audit for NBH.

A suggested starting point may exist during the clinical coding process where identification of nuances and omissions of documentation are evident.

Implementing a process for monitoring and reporting of electronic signature compliance and timeliness for outpatient correspondence will reduce the potential risk of omitting the delivery of handover documentation to referring doctors.

It is suggested that the clinical workforce receive training in My Health Record around their professional and legal obligations, in particular those addressing legislative requirements relating to emergency access to MHR.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Although an overall IM&T Project Plan is in place, development of a comprehensive, clinically endorsed and appropriately resourced organisational strategic plan for eMR/eHealth systems and clinical and business intelligence, could assist in ensuring a deliverable road map and clinical priorities for systems development.
Recommendation:
NBH develop an organisational IM&T strategic plan and road map for rolling out its digital systems and clinical and business intelligence platform.
Risk Rating:
Low
Risk Comment:
This is a strategic risk with regard to maintaining functional and safe patient record for the future and ensuring clinical documentation priorities and requirements are met.

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:

NBH undertakes a two-day orientation program for front-line clinical and administrative staff which covers their responsibilities and roles regarding safety, quality and clinical governance. Orientation is led by the NBH Executive and is supported by resources including the Healthscope orientation policy and a structured corporate orientation program. Attendance records and the employee experience evaluations are documented. This program includes requirements for nursing students, agency staff, volunteers, and contractors. There is also a two-day supernumerary period in clinical areas for nursing staff. Self-directed learning packages for a number of safety and quality risks are included in orientation requirements. Junior medical officers participate in a week-long orientation in accordance with the NSW HETI requirements. The VMO “on-boarding” orientation is currently under review.

There was evidence that NBH provides effective ongoing education in safety, quality and clinical governance, in accordance with the Healthscope Mandatory Training and the Education and Training policies. The Healthscope Education Cluster provides regular enhancements. The education and training register in ELMO documents attendance at mandatory training sessions on a rolling 12-month program. Mandatory training requirements are periodically reviewed, and recent inclusions have been updated training for end-of-life care, cognitive impairment, bedside clinical handover and ATSI cultural awareness.

Clinical Nurse Educators provide opportunistic education as well as formal education sessions in all wards to ensure that the list of required competencies are achieved in each department. Other regular

education is provided in the medical specialties and allied health specialties. There is a suggestion that Allied Health Professional (AHP) specific training is included in the NBH Education Calendar.

Clinical simulation sessions in the simulation laboratories are well attended, as are the simulation sessions in ICU and ED. Neonatal and paediatric resuscitation is regularly scheduled in the simulation laboratory. There is a suggestion in Standard 5 Comprehensive Care in regard to mapping the various training activities of NBH into a comprehensive document which could then form the basis by which the organisation determines the training schedule for the organisation.

There are a number of strategies to improve the cultural awareness of the workforce to meet the needs of Aboriginal patients, with clear evidence of uptake by staff. These strategies include “asking the question” ELMO training for administrative staff, and the “share our pride” video. There was a smoking ceremony at the front of the hospital as part of NAIDOC week. There is a new nursing graduate mentoring program involving a first nations clinicians support group which is an excellent initiative.

The Healthscope performance review and development policy requires staff to participate in review of their performance, and the performance development process at NBH. This is monitored using the Kronos system. Healthscope human resources department is available to support complex performance issues.

Performance review identifies specific training needs and identifies skill gaps, as does the national shared learnings initiative. Each nursing educator undertakes a training needs analysis in their respective department and develops a calendar of appropriate development activities, like online training and simulation sessions. There is a similar process for junior medical staff, coordinated by the Director Pre-vocational Training and Education (DPET). The supervision processes in allied health identifies the training needs of Allied Health Professional (AHP) staff.

VMO performance is reviewed and monitored by the Executive in a variety of settings like clinical review meetings, medical craft meetings and MAC meetings. Any concerns regarding performance are escalated according to the requirements of the By-Laws.

There is a well-structured process for the credentialing of medical, nursing, pharmacy and allied health clinicians. Defining and monitoring their associated scope of practice is in place, within a well-defined policy framework, guidelines and governance structure. Credentialing of medical staff, including re-credentialing for innovative technologies, is outlined in the By-Laws, and undertaken by MAC. Scope of practice is available hospital-wide via the e-credentialing system and is a valuable tool for interventional suite nursing staff. Regular auditing of compliance with VMO credentialing and scope of practice via the cGov system is undertaken, currently 100% compliant, and the results are reported to Healthscope nationally.

There are some specific credentialing activities undertaken at NBH including CPAP credentialing in Special Care Nursery, Waterbath credentialing in Maternity, Oncology credentialing in pharmacy and in the day infusion unit. Nursing and Allied Health registration and credentialing resides with the NBH Workforce People and Culture Committee. Any credentialing risks are escalated to the PCRC and Executive team. Compliance currently sits at 100%. It was noted that of 1600 births in the last 12 months, only nine newborns were retrieved to higher level care which is testimony to the outstanding efforts in credentialing and training staff in the Special Care Nursery.

The assessment team noted that the requirements outlined in Advisory AS18/12 for colonoscopy credentialing were met but there is a suggestion to capture the documentation in the credentialing system.

The organisation's performance development policy outlines safety and quality roles for all managers and clinicians. Position descriptions of all clinicians define responsibilities for safety and quality, as do the By-Laws for the VMO contracted staff.

There was evidence of appropriate supervision of the clinical workforce, particularly graduate nurses, junior medical staff and junior allied health professionals. Overnight medical staff are supervised by on-call specialists.

The health service supports the clinical workforce to provide safe, high-quality care with the provision of a range of best available evidence including guidelines, care pathways, screening and assessment tools, decision support tools and clinical care standards from the ACSQHC. All these resources are accessible via HINT.

The assessment team noted the considerable efforts undertaken to implement some of the clinical care standards, like the acute coronary syndrome clinical care standard, the delirium clinical care standard and the colonoscopy clinical care standard. The implementation of some other clinical care standards like OA Knee Clinical Care Standard is being progressed. Monitoring of the ACSQHC hospital acquired complications has demonstrated improvements better than published peer rates, and this data is reported to the Healthscope Executive Board.

As part of a system to reduce variation in clinical practice, there was evidence that processes of care and health outcomes are regularly reviewed and that these are compared to performance data from other Healthscope facilities, and selected clinical quality registries, such as Australia and New Zealand Intensive Care Society (ANZICS) adult, the national joint registry and perinatal data collection. Mechanisms exist to detect, investigate and act on unwarranted clinical variation within the health service, and to record risks within the risk management system and credentialing systems. The morbidity and mortality (M&M) meetings at NBH are maturing under the supervision of the new clinical leadership structure.

Any concerns regarding a clinician are escalated to the Executive and in the case of VMO's are reviewed in accordance with the By-Laws.

Suggestions for Improvement:

NBH includes AHP specific Education in the NBH Education Calendar.

The cGov credentialing file system incorporates documentation regarding the recertification of colonoscopists in accordance with Advisory AS18/12.

Safe environment for the delivery of care

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

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

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

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

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The NBH has now been in operation for 12 months and it continues to look brand new. The building complies with the Building Code of Australia (BCA) and the disability code. The design of the building incorporates a comprehensive building management system (BMS); where, for example, faults can be detected early in the operation of the elevators and the technician will be notified to bring the faulty part prior to a breakdown. The NBH facility's ongoing maintenance is managed by an external contractor (Ventia). Ventia engineers are on site Monday to Friday with 24/7 on-call support via a help desk. In the last quarter, NBH has commissioned a new Committee to oversee the ongoing governance of the facility. NBH conforms to the Healthscope policies that directly relate to the maintenance of the building including Hazard management, fire risk minimisation, WHS requirements and a facility business continuity plan. The Executive receive a monthly facility management report from Ventia on compliance with the maintenance schedule, which includes a `hot list' critical success factors that need to be addressed.

NBH operates under a number of Healthscope policies that include situation management of things such as workplace aggression, duress codes, information security, mental health security and training; that provides strategies for the staff to minimise the risks for patients, carers, families, consumers and the staff. Over the last 12 months, NBH has developed specific policies for their facility that deal with mental health practices, aggressive incidents, switchboard procedures and licencing requirements. The NBH Security Manager holds the master security licence for the facility.

NBH policies and plans adhere to relevant standards including the intruder alarm systems, closed circuit television (CCT) and security guards and patrols. Comprehensive security measures have been put in place and evaluated to manage unpredictable behaviours that include risk assessments, security officers (now in-house staff) in ED 24/7, CCT throughout the facility, a lockdown plan and the ability to lockdown from the central security office, photo ID swipes, fixed and mobile duress alarms, intercoms and door control. All security incidents are recorded on the RiskMan incident reporting system. More recently Program Evaluation and Review Technique (PERT) security risk assessment has been completed.

NBH provides the following calm and quiet environments for staff, patients and families, which include single rooms, family conference rooms, multi-faith room, seclusion room in mental health and safe assessment rooms in ED. The NBH facility has all the signage required to meet the building code of Australia, including emergency exit signs and disability signage. Prior to opening 12 months ago, NBH did a lot of work in engaging and consulting with consumers and disability groups to use some of the access points and to provide feedback on the way-finding required to support all users. Since opening, NBH has continued to look at improving signage and recently updated the signage to ED with red lines on the

floor. While a survey indicated 70% satisfaction from patients and visitors on the new signage, the assessors suggest that there may be some further room for improvement.

NBH operates under the Healthscope policies for the code of conduct and the management of visitors, but over the last 12 months, NBH has developed specific policies for their facility that deal with visitors in ICU and the Interventional Suite; a paediatric visiting policy and a mental health unit visiting policy. Information on flexible visiting arrangements is on the NBH website, the admission information pamphlet and the patient information directory. Some examples of flexible visiting at NBH include fathers of new babies staying overnight, end-of-life care patients can have extended visiting and children under 16 must have one parent stay with them overnight.

NBH has adopted the Healthscope policy on acknowledgement of country and have the Aboriginal flag on display at the entrance to the hospital. NBH held a local launch during NAIDOC week (June 2019) of their Reconciliation Action Plan (RAP) and a RAP working party is working on local indigenous strategies for improvement. The assessors noted that a welcome to country was given at the beginning of introductions and meetings. Cultural awareness training is provided to NBH staff and they are very fortunate to have a very proactive Aboriginal Consumer Consultant who assists in this area.

Suggestions for Improvement:

It is suggested that the current environmental checklist be expanded to include the assessment of risk for the consumer of self-harm and impulsive behaviour.

The assessors noted that some consumers had difficulty in accessing the Emergency Department through the main entrance due to unclear signage adjacent to the Concierge desk and also the long distance of the internal corridor. It would be timely for NBH to review the `way finding' signage to make clear the internal Emergency Department access point and also to advise consumers that they may access wheel chair support from the concierge staff.

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:

Involvement of consumers in the service planning of NBH occurred from the early planning of the facility. The Consumer Advisory Group (CAG) was established in 2015 and continues to facilitate and provide consumer led engagement and communication.

NBH has multiple policies and procedures around partnering with consumers, both Healthscope Corporate and local policies. A 'Patient Partners' - Consumer Engagement Plan, which expires at the end of this year is currently under review, and NBH are engaging with the consumer consultant team to provide valuable input into the new plan.

Consumers are fully supported from a governance level, and the Corporate Consumer Committee feeds directly into clinically led Patient Care Review Committee (PCRC) and onto Executive. WebEx teams exist for both consumer participation and ATSI and reconciliation groups. Consumers Consultants sit on all relevant committees, are involved in patient rounding and reviewing of various written resources and education programs.

The Healthscope Corporate Terms of Reference outlines the risk management strategies associated with this Standard. NBH has identified a primary challenge of ensuring the Consumer Workforce remain engaged and are currently working on a number of strategies to promote the purpose and value of volunteers and consumers within the clinical setting. The introduction of consumer rounding within the clinical setting has been the first step in this process.

Training on partnering with consumers for both Consumer Consultants and clinical staff is provided. Patient experience surveys are widely used to obtain consumer feedback. The introduction of Junior Medical Officer (JMO) communication training is an excellent example of how consumer feedback has influenced education requirements of junior medical staff.

The Healthscope Consumer Engagement Plan 2016-2019 discusses several performance KPIs for partnering with Consumers, with audits which are benchmarked with similar size organisations. The Quality and Safety Plan also includes performance KPIs and audit outcomes for this Standard.

Corporate consumer consultants participate in the review and analysis of all Healthscope safety and quality data as directed by the Healthscope Shared Learning Report. Consumers are involved in the analysis of incidents, near misses and complaints, while all department meetings review these matters as standard agenda items and are featured on clinical department "PERFORM" white boards.

Patient satisfaction data is presented monthly to the PCRC, while the Qualtrics patient experience dashboards provide real-time feedback to clinical unit heads. Results are examined by the Consumer Committee and published on the Healthscope Website and in "Pulse" magazine.

Healthscope's "Back to Bedside" initiative directs clinical activities toward a patient-centred model, with a focus on "Always" events based on consumer identified priorities.

Education on patient-centred care is delivered to all staff at orientation, with additional training delivered to JMOs on communication with consumers. NBH compliance with patient-centred care education exceeds the Healthscope mandated 92%.

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:

Information on the Charter of Healthcare Rights is collated within patient information packages, displayed in all patient areas, and is discussed with patients at the bedside. This information is also available in other languages via the HINT website. Mental Health areas pay particularly close attention to ensure consumer understanding of their rights and responsibilities.

An inpatient survey conducted by consumer consultants demonstrated very high compliance with receipt of relevant information.

Policy documents and standardised consent forms for informed consent for procedures, blood transfusions and financial consent (Advisory AS18/10) are in place. NBH uses interpreter services as required to ensure valid consent is achieved. The process for ensuring signed informed consent is robust, with several checkpoints and hard stops prior to patients entering pre-anaesthetic areas.

A policy and training around release of patient information is in place to ensure staff awareness on correct procedures for releasing any patient information. Policy documents also exist for use of social media and use of photography.

Regular audits on consent forms demonstrate very high compliance. Information on informed consent is available in the patient information packs and admission points throughout the hospital. NBH is currently reviewing their process around consent for ECHO procedures.

Policies, procedures and numerous resources are available for staff and patients regarding advocacy and guardianship, advance care directives and end-of-life care. Tools and risk assessments (e.g. cognitive impairment, mini-mental state exams) are utilised to alert staff to assist in identifying patient's capacity to make decisions about their care. Staff are also trained in assessing a patient's capacity. Family meetings are utilised to assist in the identification of substitute decision makers when the choice is not clear. Social worker referral occurs where required.

Information regarding a patients next-of-kin or substitute decision makers is readily available via WebPAS, while specific documents are contained within the patient's record.

Multiple policy documents and patient resources are in place around engaging with consumers, purposeful patient rounding, discharge planning and clinical handover. Communication regarding discharge planning, such as family meetings and interactions with patients and carers, are documented in the patient record.

Care planning is discussed with Mental Health consumers who are encouraged to sign their agreement with the plan, with the percentage of signatures acquired forming part of the Mental Health clinical indicator set. Mental Health patient records are reviewed as part of a team effort to ensure patient involvement in care planning and decision-making.

Results and feedback from patient satisfaction surveys are used to improve consumer involvement in their care. Examples of improvements have included JMO communication and de-escalation training, comprehensive documentation of discharge planning, records of family meetings, case conference notes and implementation of discharge phone calls for all Day of Surgery Patients and Occupational Therapy (OT) home visits. Other initiatives have included use of care boards, patient journey boards and purposeful rounding.

NBH recently completed a comprehensive care project aimed to increase utilisation of care plans and subsequent documentation of consumer involvement in planning of their care. “Back to Bedside” has been endorsed by Healthscope as part of their strategic plan, and training on this is provided to all clinical managers at orientation. Purposeful patient rounding empowers patient engagement with staff, managers and executive. Recent implementation of the REACH pathway to encourage families and carers to escalate care requirements when they are concerned has also raised staff awareness of involvement of patients, carers and families in their care.

Bedside clinical handover was observed on several occasions with consumer involvement and completion of care boards evident. A recent audit of clinical handover demonstrated very high compliance with involving the patient and/or carer in handover and goal setting. Immediate feedback to clinical staff is provided during the audit process. Rounding conducted by the medical team occurs at the bedside with patients and carers where available, and comprehensive planning of care occurs via coordinated care meetings.

The Qualtrics Patient Experience Survey feedback on patient involvement is available in real time, while staff survey results provide valuable feedback on partnering with consumers in their care. Consumer consultants participate in rounding and receive training on how to talk with patients and conduct surveys.

Implementation of MyCard in Emergency Department provides information to the patient on why they are waiting, what they are waiting for and any medications received. This assists to inform patients on their care plan and reduces medication errors.

All clinical staff complete training in clinical handover and health literacy. The implementation of REACH pathway which empowers patients and carers to escalate care has raised staff awareness of the importance of consumer and carer involvement. The Minimising Patient Harm Committee has identified a need to further develop and embed a consistent approach to patient rounding across all clinical areas.

Suggestions for Improvement:

NBH could strengthen compliance with Action 2.5 by conducting an audit of healthcare records to determine appropriate documentation about a patient's capacity to make decisions, confirmation of substitute decision makers, advocacy and/or guardianship, and whether the patient's wishes have been followed as described.

Further evidence of compliance with Action 2.6 could be confirmed by conducting a patient record audit to determine whether relevant information was documented about care options, patient and carer involvement in care planning, discharge planning and goals of care.

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:

A number of policy documents are in place around communication, including the use of interpreters to address the needs of the culturally and linguistically diverse (CALD) population. NBH has examined the diversity of the population within its WebPAS; however, would benefit from corroboration with Australian Bureau of Statistics (ABS) statistics to ensure reliability of these figures.

Service partnerships with several local community client groups have been established; however, NBH could benefit by expanding these to meet the needs of a broader range and diversity of the population served. A range of culturally appropriate information is available via multilingual consumer and carer information packages and resources.

Requirements for interpreter services are identified at entry points to the organisation and organised accordingly. An extensive range of telephone and physical interpreters are available. NBH also have beds in ICU that 'speak' twenty different languages, ensuring that linguistic needs are readily available for patient care needs. Carers and family are encouraged to be present on admission and at bedside handover, and this opportunity is utilised as an opportunity for involvement in care planning and decision-making.

NBH has a relatively low percentage of patients identifying as Aboriginal and Torres Strait Islander, with a notable proportion of responses recorded as "Not Stated". NBH has conducted education and training at entry points to "ask the question"; however, regular reporting on compliance outcomes will assist in raising staff awareness of accuracy and specificity of this important data, as well as provide information on target areas for improvement.

NHB has a well-established process for involvement of consumers in review of internally developed patient information and complies with the corporate policy regarding consumer approved publications. Consumers on all corporate clinical clusters review information written for consumers and provide feedback utilising a Consumer Feedback Form to facilitate their review responses. A consumer approved logo is applied as recognition of this process.

The workforce, patients and carers have ready access to information about services provided by NBH, in addition to resources relating to specific conditions. Information is provided in consumer reviewed plain language, while multilingual brochures are available on the public website. Clinicians have access to MIMS consumer fact sheets which are used to provide education to patients and carers on medications.

Patient-Centred Care Plans are discussed with all patients, family and carers and documented within the patient notes, and VMOs adhere to guidelines on clinical responsibilities required to support informed clinical decision-making stipulated by the Healthscope By-laws.

Healthscope reports key quality and safety outcome data to the general public on the MyHealthscope Website to facilitate informed decision-making regarding the selection of their care and admission. Medical discharge summaries are provided to the patient and sent to the patient's GP on discharge, and clinical staff ensure any external resources to support patients after discharge are arranged. Compliance with Discharge Summary completion is monitored and reported to Executive monthly.

Staff are trained in the use of "KICK-T" communication methods, while ISBAR is utilised during bedside clinical handover to ensure families and patients are engaged in their care. Survey results relating to the "Back to Bedside" initiative aimed at improving patient experience and patient-centred care implemented in mid-2018 have already demonstrated significant improvement in patient satisfaction. Audit results demonstrate very high compliance with all key components of clinical handover. Implementation of the REACH Program has also empowered carers and family to escalate care if required.

Feedback from patients and carers about information communicated to them is included within the Patient Experience Survey.

Suggestions for Improvement:

NBH would benefit from reviewing ABS statistics to ensure reliability of culturally and linguistically diverse population within its catchment. NBH has conducted education and training at entry points to "ask the question"; however, regular reporting on compliance outcomes will assist in raising staff awareness of accuracy and specificity of this important data, as well as provide information on target areas for improvement.

Although some questions on cultural and religious needs are included in YES surveys, the conduct of a survey specifically tailored towards consumers with culturally or linguistically diverse background may assist in determining whether communication processes are fully meeting their needs, or if opportunities for improvement exist.

Patients understanding of communication during bedside handover could be improved by a concentrated effort to reduce the use of complex medical terminology and acronyms. Staff education and training around use of language, followed by audit at handover will assist in improving the simplicity of language used when communicating with patients and carers.

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:

Consumer Consultants are intrinsically involved in improvement of service delivery and strategies, including the Healthscope and NBH Safety and Quality Plans and Strategic Plans. NBH has a Stakeholder Engagement and Communications Strategy and consumers sit on the Patient Care Review Committee (PCRC) and other key committees.

All consumers are recruited appropriately and formal position descriptions outlining their roles and responsibilities are in place. Although consumer representation has recently been expanded, further recruitment of a greater number of culturally diverse consumer representation is encouraged.

Consumers were extensively involved in the original design and function of the new NBH facility from the outset. The Consumer Advisory Group (CAG) was established in 2015, providing valuable input and advice on numerous aspects of the new hospital. Consultation included special interest groups such as disability and visually impaired representatives to ensure appropriate aesthetics, access and safety.

Volunteers were involved in development of "The Guide" to assist patients and visitors with wayfinding and signage improvements. In addition, the Concierge desk has developed 'cards' to direct patients to specific doctor's rooms for their appointments.

Corporate Consumer Consultant Committee minutes clearly demonstrated consumer involvement in the draft of the new Consumer Partnerships Engagement Strategy 2020-2023 which outlines proposed strategies in addition to recapping on progress to date. The five key initiatives outlined in the 2016-2019 plan which included bedside handover, patient rounding, patient experience, consumer approved publication and engaging consumer consultants, were all successfully achieved by NBH.

The Disability Liaison Group has reviewed the high-care needs of patients living at home, with review of patient experience and feedback. In addition, consumer feedback has streamlined processes around medications information to GPs following patient discharge.

Development of the Ways to Wellness books, Discharge Planning and Resources Workbook and other publications for Mental Health patients provide excellent examples of involvement of consumers in the planning, design and evaluation of their care. Similarly, audit results of comprehensive care planning demonstrate involvement of Mental Health consumers in their care, some components of which could provide extended benefits if translated to the general clinical setting.

All consumer representatives undergo organisational orientation and training in their roles and responsibilities and receive a Corporate Consumer Orientation package. In addition, multiple resources are available on the HINT website to assist with education and training of consumer representatives. Consumers have recently been trained in patient rounding, and now provide support to patients if they desire. Further training has been provided to consumer consultants on assisting patients to order their meals, orientating and settling cognitively impaired or delirious patients in emergency department, and falls prevention.

Consumer representatives are part of the Quality Team and have opportunity to provide feedback with regard to improvement of the effectiveness of the support provided.

Healthscope has an ATSI peoples WebEx cluster which has a senior advisor in Aboriginal policy and provides expert advice on Aboriginal affairs. NBH has two representatives on this group, where consultation on local health issues and cultural appropriateness training are discussed.

NBH has established relationships with the ATSI community and has recently launched their Reconciliation Action Plan aimed at fostering a culturally safe and supportive environment, with guidance from an Aboriginal Consumer and member of the community.

NBH engages with the Aboriginal Heritage Council which recently assisted with NAIDOC celebrations and education to staff.

Staff undergo training and various resources are available regarding cultural capability and awareness of ATSI people's healthcare needs.

Healthscope clusters, which include consumer consultants, are tasked with the review of training requirements for specialty areas. Consumer consultants are involved with staff orientation and have representation on the Hospital Education Committee. NBH has had several videos recorded as part of the staff education program which feature consumer consultants sharing patient stories. Expansion of this library of resources to include greater diversity and poignant messages is encouraged.

The clinical workforce participates in several training opportunities relating to partnering with consumers. The NBH Education Committee receives feedback on education and training from the Consumer Consultant Team.

Suggestions for Improvement:

NBH work on expanding their consumer representative workforce, including recruitment of a greater number of culturally diverse consumer consultants.

Although active attempts to recruit staff of ATSI heritage do occur, it is suggested NBH review its workforce to ensure a representative number of ATSI people are employed within the workforce, including engagement of appropriately trained ATSI liaison officers.

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:

Infection control systems have been implemented in accordance with Healthscope Corporate and NBH policies and procedures and in line with Australian Guidelines for the Prevention and Control of Infections in Health Care and the NSW Department of Health.

All Infection Control Policies are available on the Healthscope Intranet (HINT).

The Infection Control Committee Terms of Reference (TOR) are established. The TOR has a defined reporting structure which includes Healthscope Corporate Quality KPI's and HAC data.

The membership is well represented by all clinical departments and support services, as well as the Infection Control Coordinator and HICMR Consultant.

There is also an Infection Control (IPC) Management Plan which is reviewed annually by the Committee.

HICMR Infection Prevention and Control (IPC) Policy Manual, Toolkits, Risk Assessments are comprehensive and available through their e-portal which are easily accessible for staff to access.

The HICMR Infection Prevention and Control Risk Assessment report August 2019 describes eight (8) core criteria to be audited. Results thus far have been very positive and support the good infection control practices across the hospital.

The Antimicrobial Stewardship Program (AMS) is underpinned by Global and Therapeutic guidelines as well as NBH policies and procedures.

It was evident at the time of the assessment that the hospital has engaged with patients and consumers in relation to infection control prevention. There is specific consumer information in the Patient Information Guide regarding hand hygiene, IV Access devices, VRE and MRSA.

Pre-admission and assessment tools also provide patients with information regarding risk factors and the management of infectious diseases. Patients are well educated by the clinical Pharmacists.

The Consumer Consultants also take an active role when talking with patients about infection control. Patient communication boards are also used to help patients and families to understand the importance of infection control procedures. The hospital is encouraged to keep up the good work.

The Infection Control Coordinator is a member the National Infection Prevention and Control Cluster whereby evaluation and benchmarking occur.

The risk management approach to infection prevention is highly impressive. RiskMan is the incident management system used and has defined descriptors regarding Infection Prevention Indicator sets. Staff training commences at orientation which includes eLearning modules on ELMO, Healthscope's training portal, as well as face-to-face sessions with the infection control team. The education is well managed, and staff are well educated in all aspects of infection control.

Infection control surveillance includes the Hospital Acquired Infections (HAIs) KPI Plan which is monitored through, pathology results, risk assessments and screening, incident reports and compliance audits.

Monthly reports form part of the agenda on the Infection Control Committee, the Patient Care Review Committee (PCR), the Medical Advisory Committee (MAC), as well as at clinical and department meetings.

Shared Learnings are published and available to all sites. The information is comprehensive and extremely valuable for NBH to access and review.

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, consistent with national guidelines are in use. Precaution signs are readily available and are colour coded and easily understood.

Alerts are also captured on the electronic EMR, as well as validated screening tools. There are very good procedures in place to escalate a patient's infectious status to the appropriate qualified infection control clinical staff for assistance if required.

The NBH Infection Control Plan is comprehensive, to enable infection control practices to be managed at the highest level of governance, inclusive of physical planning, negative pressure and specialised designed areas for departments such as the Emergency Department (ED), the Intensive Care Unit (ICU) and the Interventional Suite.

Mobile PPE stations, as well as dedicated PPE stations are available. These PPE stations can easily be placed on the doors of patient rooms if required.

Cleaning schedules for environmental staff are in place and clearly explain the procedure for cleaning rooms and equipment for infectious patients.

The Preventative Maintenance Schedule is provided by the external contractor, who is represented on the Infection Control Committee.

The low infection rate is testament to the dedication and commitment by all staff in this regard.

Hand Hygiene is deemed a high priority and continues to be reviewed throughout all clinical and non-clinical areas in accordance with the hospital's Hand Hygiene Management Plan and National Hand Hygiene guidelines. Staff education commences at orientation and regular information sessions are conducted internally and externally. Results from audits are reported to the appropriate committees and service areas. Gold Standard Auditors have been trained and are involved in the 5 moment's observational audits in all clinical and non-clinical departments.

Hand hygiene ABHRs are available at the point of care. The Infection Control Coordinator, with the assistance of the infection control champions monitor the availability of hand hygiene ABHR's through-out all departments especially the high-risk areas.

Hand Hygiene compliance is over 85% which is above the Healthscope benchmark.

A Patient Survey was conducted for World Hand Hygiene Day to determine staff's compliance to hand hygiene practices from the patient's perspective the results overall were positive. From the results, the introduction of Bed Bath wipes for bed bound and reduced mobility patients is to be congratulated.

An Aseptic Non-Touch Technique Risk Assessment is in place and underpinned by the Healthscope Aseptic Policy and Mandatory training policy. The risk assessment outlines and describes what procedures are rated 'high risk' and who performs those procedures. Clinical departments and staff who work in high risk areas are trained in aseptic technique which includes eLearning education.

Audits are detailed, showing compliance over 90% in all high-risk areas. Mandatory training is captured on ELMO the Healthscope education database.

There are a raft of policies and procedures in place regarding the insertion and management of invasive devices.

Education and training include workshops such as Cannulation, which are undertaken three times a year.

The Invasive Devices Audit 2019 results show a 97% compliance which is to be congratulated.

The hospital is impeccably clean and clutter free, which is due to the diligent management of all support departments in accordance with the comprehensive range of policies and procedures in place.

'Clean utility' and storage areas are clean and consumables, with medicines well segregated and labelled. Imprest levels are in place and minimal stock is kept.

The stainless shelving in all rooms is to be congratulated.

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

Environmental Audit and PPE audits are regularly conducted and show over 95% compliance thus far in 2019.

Cleaning schedules for environmental services are in use and staff well trained. Cleaning trolleys are well equipped with standard products and PPEs in place.

Material Safety Data Sheets (MSDS) were displayed in all dirty utility rooms and areas where chemicals are stored.

The segregation of waste is extremely well managed by the staff and external contractors, from the point of generation through to disposal. The waste segregation area is highly impressive with dedicated secure holding rooms for specific waste pick-up.

Linen is also provided by an external contractor and managed well in relation to industry infection control guidelines. The Interventional Suite uses disposable linen and custom packs only.

General maintenance, and a Preventative Maintenance Schedule, is provided by the external contractor who is also represented on the Infection Control Committee.

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

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

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

There has been significant work undertaken to increase the immunisation status compliance for all staff. Over 92% of staff have their records recorded. The medical workforce is also providing immunisation records as part of the credentialing procedure.

Immunisation status records are required for all new employees and a database has been established.

The uptake for flu vaccinations is also over 90%, which is a great achievement.

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

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 hospital's cleaning, disinfection and sterilisation practices meet all current AS4187:2014 and GENCA guidelines.

'State of the Art' technology and equipment, as well as the design and layout of these service areas support and enable the well qualified staff to work efficiently. The automated instrument tracking system is highly impressive. Instruments are bar-coded which allows verification of processes at each critical phase. The reprocessing of scopes is also diligently monitored and recorded. Observing the staff working in CSSD demonstrated a clear understanding of their roles and responsibilities.

Loan sets are managed extremely well with a dedicated staff member who is experienced and highly trained in this area.

Equipment education has been conducted in relation to Washer Disinfectors, Sterilisers, Sterrad low temperature sterilisers, Ultrasonic and Chemical dosing, Scope reprocessing and drying cabinets.

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 is underpinned by Healthscope and NBH policies and procedures.

The Infection Control Committee oversees the AMS Program however the Medication Safety Committee is clearly involved. The program has also incorporated the core elements, recommendations and principles of the current Antimicrobial Stewardship Clinical Care Standard.

There has been significant work undertaken by the recently convened AMS subcommittee. The committee membership has been strengthened by the inclusion of dedicated medical staff.

A traffic light chart is used to monitor the prescribing and appropriateness of antibiotics. The chart was well displayed in all wards and critical care departments such as ED, critical care wards, as well as the Interventional suite.

A restricted antibiotic formulary is well established and monitored diligently by the pharmacists. Clinicians are well engaged and are working closely with the Pharmacists and Microbiologists in this regard. Therapeutic guidelines are readily available via the intranet (HINT).

Dedicated Sepsis Boxes have recently been introduced and are in wards and specialty areas. Sepsis pathways have also been introduced for adults and paediatrics. They are comprehensive clear and easily understood.

NAPS and NAUSP Audit results are presented at the AMS subcommittee, PCRC, MAC craft groups and relevant committees.

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:

Governance is provided through the multidisciplinary Medication Safety Committee (MSC), which meets monthly to report and monitor medication safety activities across NBH. The MSC reports through the Patient Care Review Committee and is charged with monitoring incidents and risks, approving the drug formulary, reviewing drug utilisation and individual patient use approvals. The Medication Safety Committee also monitors the current build of the electronic medication management system (eMed), due in early 2020. The extensive eMed planning is also underway to include design goals to reduce 'alert fatigue' in the prescribing workforce, as well as to define the dose adjustment rules for impaired renal function.

Quality improvement activities are guided by the NBH-wide audit schedule, key performance indicator suite, analysis and trends from the incident management system, and issues identified on the risk register. Near-miss incidents and clinical pharmacist interventions also form the quality improvement activities at NBH, including an intern orientation medication safety workshop for junior doctors, currently being reviewed for orientation in February 2020. A PBS prescribing module has been introduced as a result of analysis of pharmacist interventions.

Consumer engagement is enhanced by the extensive unit-based clinical pharmacy service, where clinical pharmacists are embedded into unit activities like rounds, huddles, education sessions and various unit meetings. Clinical pharmacists engage regularly with patients and carers during their journey, from admission to discharge. A trained consumer approves the brochures and information for patients, and there is a focus on ensuring compliance with the health literacy parameters.

Credentialing of all staff involved in medication prescribing and administration is undertaken and reported through to the MAC credentialing committees as well as via the Kronos system. Junior doctors, graduate nurses and inexperienced pharmacists are well supervised and mentored by appropriately credentialed staff. Credentialing of nursing staff is comprehensive, and the various roles in checking of high-risk drugs is well understood. Credentialing of extended roles of pharmacists is undertaken by the third-party pharmacy provider.

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:

The clinical pharmacy service documents the patient's best possible medication history, in collaboration with other health professionals, using at least two sources of information, like the patient's own medications and community pharmacists. Medication charting is accomplished on the NIMC and the PBS chart. EviQ prescribing is in place in the Oncology infusion centre. Compliance with VTE prophylaxis prescribing is high, although the documentation on the risk assessment screening tool is not always completed. This remains a focus of activity.

Clinical pharmacists regularly reconcile the NIMC medication charts against the Medication Management Plan (MMP). The MMP includes risks like age, smoking, polypharmacy, obesity indices and non-compliance risks. Decision support for prescribing and administration is available at the point of care via electronic systems, as well as hard copy manuals.

A printed discharge medication list is produced for all patients from the eMR. Medication reconciliation on discharge or transfer is well performed.

Adverse Drug Reactions (ADR) are reported on the incident management system and to the peak committees, as well as the TGA. Patients with known allergies have a red identification band. Allergies are well documented. Incidents relating to allergy and ADR are reported to the peak committees.

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:

Medication reviews are undertaken in partnership with patients identified at risk by the MMP, including risks of polypharmacy and poor compliance. Annotation of charts and the MMP by the clinical pharmacists (in purple pen) assist safer prescribing and administration of medications. Medication lists on the eMR are readily available for patients and carers and at points of transition in the patient's journey. These lists are updated regularly by the clinical pharmacists.

Medicine related information is provided to patients in a number of ways. Discharge counselling is undertaken by the clinical pharmacists, particularly for new and high-risk medications. Consumer leaflets are provided, like the pain leaflet for post-operative patients. The medicines list on discharge includes current medicines and reasons for any changes, as well as side effects.

Medication management processes

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

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

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

Assessment Team Summary:

There is good access to decision support tools for clinicians available on HINT and the eMR quick links, including eTG, MIMs, the Australian Injectable Drug Handbook and the Australian Medical Handbook (Paediatrics). Royal Children's Hospital Injectable guidelines and Westmead Children's Hospital guidelines are well utilised in the Paediatric area.

Medication rooms and medication cupboards were all secured across the organisation, accessed by swipe card and keys by appropriately authorised staff members. The ICU medication room has been redesigned as high priority to improve security of this area. Other medication rooms have improved lighting, noise control, medication preparation areas and safer labelling areas.

Safer labelling is achieved by Tallman lettering on shelving and “shelf-talker” labelling for restricted antibiotics. User-applied line labelling is well embedded. There are various types of the storage of individual patient’s medications in the mental health medication rooms, and there is a suggestion to standardise this storage in the mental health wards.

Cold chain management of all medication-grade refrigerators and vaccine grade refrigerators is centrally controlled in NBH, with immediate notification of ward NUMs when there is any breach outside the range 2-8 degrees. A cold chain breach procedure then outlines the quarantining and assessment of affected stock.

The pharmacy manages the recycling and disposal of medications.

High risk medicines defined by the APINCH acronym are managed through an integrated system of policy, guidelines, forms, education and tools. There is regular reporting of any incidents to the MSC. There have been many initiatives to improve safety of these drugs. Potassium ampoules have been removed from all areas except ICU and ED resuscitation area. Controlled drugs like opioids and medicines with the potential for abuse have been a focus of the MSC, resulting in safer storage of Hydromorphone, and of Propofol in the intervention suite. Tamper evident bags have been implemented to assist with the safe storage of patient’s own medications in this class.

The management of Methadone dosing is the responsibility of the Nursing Director via the Drug and Alcohol CNC given the Section 90 status of the third-party pharmacy department. It is noted that there has been extensive communication with the Ministry of Health in regard to the safety of Methadone dosing in hospital wards. However, it is suggested that the security of Methadone dosing in the general wards requires further review. There is also a suggestion to enhance the identifiers used for patients in the Methadone register under Standard 6.

Suggestions for Improvement:

NBH standardises the boxes used for the storage of the patient’s medication in mental health medication rooms.

NBH undertakes further review of the security of Methadone dosing for patients in the general wards.

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:

Safety and quality systems have been implemented to support clinicians to deliver comprehensive care and minimise harm, which are congruent with the Clinical Governance Standard 1 across NBH.

There is governance oversight through the Patient Care Review Committee, Mental Health Quality and Safety Committee and the recently formed Minimising Patient Harm Committee. Each have clear roles and delegated responsibilities and provides scheduled reports to the Executive and Healthscope Board Safety and Quality committees. An additional six subcommittees have been endorsed to provide operational support and advice on specific patient harm risks.

State, Corporate (Healthscope) and local policy and procedures are well structured, and accessible to staff electronically. Governance frameworks support the development and control of such documents as described under Standard 1. Observational audit and discussions with clinical staff during the assessment, demonstrated that staff understand and practice within established guidelines.

Quality improvement methodologies are utilised to mitigate risks associated with patient harm and to monitor, respond to and evaluate care. Extensive auditing schedules and performance indicators, measuring compliance and clinical outcomes are generated from a local, corporate and state level. Benchmarking occurs at a corporate and industry level. Incident analysis, clinical reviews, mortality and morbidity reviews and patient feedback are also utilised to monitor and measure the effectiveness of the system. Feedback on performance is provided through a series of performance quality and safety reports to the Board, Executive, clinical staff and operational safety committees. Action is taken to reduce risks identified at a unit and organisation level.

Training is provided to the clinical workforce at point of entry into the health service and throughout the period of employment. Such training is provided through a range of formal and opportunistic learning opportunities. Over the last 12 months this has been extensive and prioritised according to clinical risk. Attendance by staff is high and positively received by staff. The schedule of training appears to have grown organically over time to respond to adverse events and compliance requirements. This has not been formally evaluated and a suggestion has been made to formally map the training activities (both at induction and ongoing) that are currently being undertaken to support the provision of comprehensive care across acute and mental health services. This information could then form the basis by which the organisation determines the training schedule and to set priorities for members of the workforce.

A person-centred approach to care is adopted as referenced in Standard 2 Partnering with Consumer Standard. Patients and their families are actively engaged in their care as evidenced by a range of innovative programs targeting the identification and communication of goals of care. Processes to encourage and support shared decision-making conversations have been introduced for the clinical workforce. Patient experience surveys rate their engagement and care delivery indices in the 80th percentile.

Systems to enable and support the delivery of comprehensive care to patients were evidenced. The electronic medical record (eMR) provides the structure by which clinical information is documented and comprehensive care plans communicated.

Processes are in place to ensure that patients are accommodated into the appropriate care setting that best meets their needs. Patient flow activities adopt a person-centred approach and are focused on placing patients in the right bed the first time and in a timely manner. The establishment of the transit lounge and initiatives such as ‘Home by 10am’ have positively contributed to patient flow and access to beds. It was noted during the assessment the increased number of admissions of children and adolescents into adult and paediatric mental health units. The risk and associated harm minimisation controls has recently been reviewed. It is listed on the organisation risk register.

The referral system is supportive and responsive to the assessment process. The use of the eMR has improved the internal referral process for admitted patients. Referrals between services, clinicians and community support agencies. Individual service/programs have a suite of formal referral pathways and prioritisation matrices. Patients and carers accessing the mental health service are provided information on additional community resources available through a range of published booklets and guides.

The clinician carrying the overall accountability for an individual patient’s care is readily identifiable. Shared care arrangements are utilised where appropriate to do so.

Multidisciplinary collaboration and teamwork are actively supported and evidenced across the organisation. Activities such as multidisciplinary huddles, structured clinical handovers, multidisciplinary meetings, case conferences, safety huddles, and clinical pathways collectively work together to build and strengthen a strong team approach to the provision of comprehensive shared care.

Suggestions for Improvement:

The work of the various committees be presented in the form of an annual action plan, that responds to the elements incorporated within Standard 5, identified risks and operational and strategic clinical objectives to provide structure and a means to monitor clinical outcomes and the effectiveness of the system.

Use the information gathered from measurement and quality improvement systems, adverse events, clinical outcomes and patient experience to inform and update risk assessments and the risk management system pertaining to comprehensive care.

Map the existing quality assurance activities currently being undertaken across all services that relate to the comprehensive care standard in order to develop a Comprehensive Care evaluation audit schedule to assess the effectiveness and performance of the system. The evaluation audit schedule could also include performance measures, target rates and response plans for each of the audit activities.

To develop a reporting framework that incorporates all areas of patient harm across the acute and mental health services with particular reference to self-harm, suicide, cognition, challenging behaviour and restrictive practices.

To formally map the training activities (both at induction and ongoing) that are currently being undertaken to support the provision of comprehensive care across acute and mental health services. This information could then form the basis by which the organisation determines the training schedule and to set priorities for members of the workforce.

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:

The clinical and psycho-social risk screening and assessment process commences prior to and at point of entry into the service. Reassessment occurs at predetermined intervals. Screening is undertaken utilising a suite of tools, (several of which are embedded within the eMR), and a positive response links to a secondary assessment. Assessments are structured, multidisciplinary and information generated from the assessment is communicated to members of the clinical workforce through a range of clinical handover methodologies and documentation approaches. Elements of the process are individually evaluated utilising a series of quality assurance methodologies. The results of these are reported and actioned at a range of committees and working groups across the organisation. These processes are well established for falls, self-harm/ suicide, pressure injury and nutrition and in the developmental phase for delirium /dementia, end of life, and aggression and violence.

The Comprehensive Care project has been established to review and develop standardised electronic clinical tools by which risk screening is attended and a comprehensive care plan created at point care. Phase 1 (adult medical and surgical) had been completed and phase 2 (speciality areas) has been commenced. Evaluation audits demonstrate a significant improvement in compliance, with risk screening and care planning processes.

Processes have been implemented to ensure all ATSI persons are identified at point of entry into the clinical and administrative datasets within the electronic systems. Persons identified are to be flagged in the specific services patient management system and in the eMR; however, reports have yet to be generated to routinely measure compliance with the process and the numbers of unstated classifications. This is further addressed in Standard 2.

Corporate and NBH processes describe how Advance Care Directives (ACD) and Health Care choices are to be managed and documented. Medical Power of Attorney/substitute decision makers nominated carers and ACPs are recorded in the electronic clinical and administrative systems.

Actions 5.7 and 5.10 are subject to Advisory AS18/14 Comprehensive Care Standard: Screening and assessment for the risk of harm. At assessment an action plan was presented addressing the requirements of the Advisory.

Clinicians use processes for shared care decision-making, to develop and document a comprehensive and individualised care plan. Care planning is based upon the assessment of the patient/consumer and is recorded in a care plan, program of care, progress note, goals of care or specific care pathway. A case management approach is adopted for persons with complex needs or who have an extended length of stay. Throughout the assessment period it was noticeable that patients are actively engaged in their care. Patient feedback indicates that 89% of patients are informed about their care and 86% are involved in decisions made about treatment and care.

Discharge planning is commenced on admission and includes documentation of the patients expected length of stay, discharge destination and referral to additional discharge support services as required. Discharge is actively managed across the care continuum.

Action 5.13 is subject to Advisory AS18/15 Comprehensive Care Standard: Developing the comprehensive care plan. At assessment an action plan was presented addressing the requirements of the Advisory.

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:

Care is delivered in accordance with the care plan. The recently developed Comprehensive Care Policy articulates the key components of an individualised care plan and staff responsibility to provide such care, in partnership with patients and their families. Both the eMR and paper based clinical records demonstrate changes to care plans in response to diagnostics, harm prevention plans, therapeutic interventions and goals of care, are made in real time and communicated to the clinical workforce.

Bedside clinical handovers and Patient Boards provide opportunities for interactive, contemporaneous conversations between patients and staff to ensure care goals are appropriate. Quality assurance methodologies such as clinical reviews, death reviews and incident analysis monitor compliance with the system and clinical outcomes.

The Patient Care Review Committee is endorsed to oversee the implementation of strategies and methodologies to assure a best practice approach to end-of-life care across all clinical streams.

End-of-life processes are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Corporate, NBH Policies and supportive clinical records are evidenced

for the management of end of life, advance care directives, medical orders for sustaining Life (MOLST) and organ and tissue donation. NBH utilises the Clinical Excellence Commissions (CEC) 'Last days of life' toolkit. The end-of-life pathway is paper based. Education of staff is through direct care conversations, unit-based education sessions and grand rounds. Clinicians support consumers and carers to make decisions about end of life. The system has yet to be formally evaluated against agreed performance measures.

The use of the CEC AMBER care bundle – starting the conversation, is the preferred methodology used to trigger early identification and referral to the Palliative Care team. The use of this or any other validated end-of-life trigger tool is in its infancy and it is suggested that the identification of a trigger tool for use across NBH be determined.

Specialist palliative care medical and nursing support is accessible to all clinical services through a referral process to Hammond Care, whom are located 'onsite' five days a week. Pastoral Care services are readily accessible.

Advanced Care Plans received from patients are documented and recorded in the administrative and clinical information systems as an Alert. Hard copies are kept by the bedside. Reference to these is made in clinical handover.

The clinical workforce has access to supervision and support through peer support, mentoring, and access to external services for a formal debriefing or counselling if required.

Death reviews are conducted for all deceased persons and findings are referred to craft specific mortality and morbidity meetings, and to the Patient Centred Care Committee.

Suggestions for Improvement:

A set of meaningful measures of the safety and quality of end-of-life care be developed with clinicians to monitor and measure the effectiveness of the system.

The identification of an early identification palliative care trigger tool for use across NBH be determined, with a scheduled roll out across all services.

It is suggested that the death audit give consideration to formally evaluating if the goals of care planned and documented and care received were consistent.

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:

NBH has appropriate systems in place for the prevention and management of pressure injuries and operates under the Healthscope Policy `Pressure Injury – prevention, identification and management'. The organisation has also developed local NBH policies over the last 12 months, specifically for use of local pressure injury prevention equipment such as the pneumatic tourniquet and Nimbus mattress. The overarching Healthscope policy incorporates the national best practice guidelines, that ensure that the relevant policies and procedures; assessment tools and pressure injury classifications are in place to support the staff with the prevention and management of pressure injuries. It is noted that the pressure injury risk assessment and care planning is incorporated into the eMR. Pre-existing pressure injuries are identified on admission during the assessment, photographed with consent, escalated to the NUM and recorded on the RiskMan incident reporting system.

The NBH audit system is directly linked and reported to Healthscope, with the pressure injury prevention audit being conducted annually. There is evidence that hospital acquired pressure injuries and any stage 3 or 4 pressure injuries acquired after admission, are reported to the PCRC. Noting that ACHS clinical indicator data is collected and benchmarked twice a year, with results showing NBH below peer group pressure injury rates. A highlight of the assessors visits to the NBH wards was to see the introduction of the `new' huddle boards in use, and in particular the focus on pressure injury prevention. All huddle boards either had the number of days since the last pressure injury or a percentage rate that was measured each day. This timely communication platform clearly articulates the performance of the wards and brings an increased focus of attention to the staff of patients at risk of pressure injury at handover. It also provides the staff with a great sense of pride and achievement on their ability to keep patients safe.

NBH utilises the Healthscope Policy `Pressure Injury – prevention, identification and management', which outlines the requirement to use the evidence-based Healthscope risk assessment tool for pressure injuries. Noting that the pressure injury risk assessment tool is incorporated into the eMR. The comprehensive skin assessment commences with the admission, on transfer to another department, with a related change in condition and on discharge. The skin assessments are communicated between staff at clinical handover, with a strong focus of pressure injury prevention at the huddle boards and it is included in the discharge summary.

The NBH pressure injury management policy identifies the importance of engaging with patients if they are diagnosed with a pressure injury on admission, or if they acquire one during their stay. Information for patients and their families at NBH begin with the NBH website that is accessible to the public via the MyHealthscope website, prior to admission. In addition, all booked patients at risk of pressure injury are provided with an information brochure (CEC brochure) and there is also written information in the bedside patient information guide.

Care planning is completed in partnership with the patient. The family and/or carer is included in these discussions. The care plans are utilised at clinical handover to provide pressure injury information to the next staff, with the patient involved in this process and patient boards in the rooms also identifying pressure injury concerns for staff and family. The risk assessment tool for pressure injuries will also prompt the staff to provide more patient information if the patient's pressure injury condition deteriorates.

NBH is well resourced with a wide range of equipment for patients identified as a high risk of developing a pressure injury. Equipment at NBH includes, but is not limited to, air mattresses, special ICU and theatre beds, lifters and heel raising devices. All of which are listed on the NBH equipment guide, so that staff are aware of the equipment resources available for pressure injury management, how to use them with appropriate safety information and how to locate them with the electronic tracking system.

NBH has appropriate systems in place for the prevention and management of falls and operates under the Healthscope Policy `Falls prevention and management - patient', which incorporates national best practice guidelines. NBH use RiskMan for their risk management system and all reported falls are reviewed by the Falls Working Party, who report directly to the Minimising Patient Harm Committee. The patient falls history is incorporated into the eMR on admission or during the pre-admission booking process. The Falls Risk Assessment Tool (FRAT) is completed on admission; following surgery or a related change in condition, on transfer or discharge, and after a fall. The eMR will automatically generate a referral to Allied Health for patients at risk of falls, to ensure that comprehensive care planning includes physiotherapy consultation.

Post-fall management at NBH includes the documentation in the medical record and RiskMan, escalation to their treating Doctor, with a CT scan ordered if there is a suspicion of an associated head injury and then preventative strategies. NBH includes a review of the Healthscope `shared learnings' as part of their post falls management, which will provide an overview of sentinel event falls across Healthscope facilities, as well as any preventative strategies identified that could be utilised at NBH. The assessors observed during visits to the NBH wards, that the introduction of the `new' huddle boards were actively used by staff; and in particular the focus on falls prevention. All huddle boards either had the number of days since the last fall, or a percentage rate that was measured each day. This timely communication platform clearly articulates the performance of the wards and brings an increased focus of attention to the staff of patients at risk of falls at handover. This appears to have enhanced staff morale, with staff speaking favourably about their non-fall rates and their ability to keep patients safe.

NBH is well resourced with a wide range of equipment for patients identified as a high risk of falls. Equipment at NBH includes, but is not limited to, low beds, chair alarm/mat, walking aids, hoists and appropriate grip socks. All of which are listed on the NBH equipment guide, so that staff are aware of the equipment resources available for patients at risk of falls, how to use them with appropriate safety information and how to locate them with the electronic tracking system.

Patients assessed as a risk of fall, over 65 years of age or confused, will have preventative strategies identified and implemented by the staff, that could include more frequent rounding, adjustment of lighting and bed height, environmental checks for trip hazards, stand-up alarm activated and grip socks in place. NBH has processes in place for the provision of appropriate equipment and devices to prevent falls and this is captured in the electronic equipment and devices register. The equipment at NBH is state of the art and in sufficient numbers for optimal patient care, including bed sides whereby each side has the option lifting fully or only half, also mobility aids, grip socks and alarms. The equipment is also easily located via an electronic tracking system to minimise delays in finding the right equipment, at the right time.

The Healthscope Policy `Falls prevention and management - patient' identifies the importance of engaging with patients and their carer if they are over 65 years of age or assessed as a high risk of a fall on admission. Information for patients and their families at NBH begins with the NBH website, that is

accessible to the public via the MyHealthscope website. In addition, all booked patients at risk of falls are provided with a Healthscope information brochure (Keeping a step ahead of falls) and there is also written information in the bedside patient information directory (under the falls section). Care planning is completed in partnership with the patient; and the family or carer is included in these discussions. The care plans are utilised at clinical handover to provide risk of fall patient information to the next staff. Patient boards in the rooms also identify risk of fall concerns for staff and family. The risk assessment tool for falls will also prompt the staff to provide more patient information if the patients pressure injury condition deteriorates. On discharge, the discharge summary includes any inpatient fall and also a referral for a home assessment if required.

It is evident that NBH utilises appropriate Healthscope policies, including Diet and Nutrition – Adult Inpatient, to ensure that the nutritional needs of patients are met. The management of nutrition at NBH commences with all patients being screened on admission with the Healthscope Malnutrition Screening Tool, which is integrated into the eMR and will generate a referral to the dietician if clinically indicated. The assessors noted that support of a dietician was not always available to all wards, and this has been identified as a suggested area of improvement.

The eMR also communicates diet needs to the food delivery service Chefmax, which offers consumer reviewed menus. Meal time assistance is being monitored. The NBH kitchen holds an `A' grade rating on its hygiene and food storage systems. The Dietician Manager and the Dietician team conducted a quality improvement initiative in September 2019 to assess NBH compliance with the Diet and Nutrition policy. The results identified some Malnutrition Screening Tool (MST) completion concerns, as well as only 14% of patients admitted more than a week, having had their weight recorded weekly. An action plan has been developed to target the education of nursing staff and a focus on weight and height documentation.

The NBH nutrition management is governed by their Food Safety Plan and also includes food menus for patients that are based on best practice guidelines and reviewed by consumers. The NBH orientation program for all staff includes education on catering and dietetic services. NBH nursing staff complete the MST on all patients at admission and then weekly. The MST is integrated into the eMR and will generate a referral to the dietician if clinically indicated. The dietetic service provides all nutritional support supplements to patients, including increased protein in between meals if required. Diet aides are utilised to ensure that correct patient diet codes are entered into Chefmax. Total Parenteral Feeding (TPN) is initiated when enteral feeding is not suitable. Dietetic services work closely with the Coronary Care Unit (CCU) to design education diet programs for the cardiac patients.

Systems are in place to identify and manage persons with delirium or cognitive impairment. This makes reference to screening, assessment, care and prevention strategies and is aligned to the Delirium Clinical Care Standard. Substitute decision makers are identified on admission.

Delirium and cognition screening commence in the emergency department and on admission to the clinical unit. NBH has recently determined that the 4AT assessment test for Delirium and Cognitive impairment is to be used as the primary screen, across the organisation with the exception of ICU whom uses the ICU-CAM. This replaces the CIRAT tool. If a positive screen is identified, secondary assessments are completed and referrals made to appropriate clinicians. Care planning is individualised and documented across the continuum of care and at discharge.

Clinical units are supported by easy access to aged care assessment teams, Aged Care Clinical Nurse Consultants (CNCs) and specialist medical practitioners at point of care. Family/Carers are actively involved in the process through the use of modified “TOP 5” tools.

The recently formed multidisciplinary Dementia and Cognitive Impairment Subcommittee, provides operational oversight and implementation of the delirium and cognitive impairment system and reports to the Minimising Patient Harm Committee.

The use of medications is well managed. Clinical ward pharmacists currently review all admitted persons prescribed psychoactive and anti-psychotics as part of the medication management review process of all admitted persons. Geriatricians provide medical oversight of all admitted persons aged 65 and over, or who have been referred to their care through direct or shared care arrangements. The mental health older persons unit has direct specialist medical and pharmaceutical input into care.

Staff are orientated to delirium and cognition practice across their employment, through a range of learning opportunities.

The system supporting delirium and cognition is monitored via incident analysis, clinical reviews and patient feedback. NBH also monitors hospital acquired delirium as part of a suite of corporate performance indicators. Trending data is low.

Initiatives to improve the management of persons with cognitive impairment and reduce harm associated with cognitive impairment, were evidenced across the service. These included the use of nursing ‘specials,’ pet therapy, modified pain assessment tools, patient rounding, music therapy, patient care boards, environmental changes, and the use of proactive sensory de-escalation practices.

State, corporate and NBH policy documents and supportive guidelines, outline the processes by which persons at risk of self-harm or suicide are identified and managed. Compliance with these documents has yet to be evaluated.

The Patient Care Review and Mental Health Quality and Safety Committees provide operational oversight, implementation of the hospital’s self-harm, suicide prevention and management system. It was unclear at assessment which committee had overall accountability of this risk across the hospital for all patients.

Self-Harm and suicide are listed on the enterprise risk register and is rated high. Risk mitigation/control initiatives have been identified, however, have not been formally evaluated for effectiveness.

Screening for mental health risks commences prior to, or at point of entry into the service as part of the general hospital assessment/admission process. Persons presenting to the emergency department, obstetric and mental health services are screened utilising approved mental health screening tools. If a positive screen is identified, the pathway for referral, secondary assessment and the ongoing care level is articulated. Care planning is individualised, safety orientated and documented in the medical record.

The mental health service utilises a range of strategies designed to respond to persons who are distressed or have thoughts of self-harm /suicide. In the general hospital setting referrals are made to specialist mental health consultant liaison teams, for advice and ongoing care. Follow up arrangements

for the transition of ongoing care are developed and communicated to the respective community service agencies and general practitioners where appropriate. Established pathways between agencies were evidenced. Persons (and/or their carers) accessing the mental health services are provided with a discharge planning and resource workbook, Northern Beaches Mental Health Services resource booklet and a copy of their discharge plan.

Staff are made aware of the system at orientation and specific training commences within the respective clinical units during the induction phase and throughout their ongoing employment. Non-mandatory training is accessible via the online mental health learning platform which is a repository of mental health topics. Predicting, preventing and managing self-harm and suicide is incorporated into the mental health nurse graduate program. Impromptu training sessions are available to staff as required. There is an opportunity to review the formal training provided to staff across all care settings to ensure that the clinical workforce has the skills and knowledge to engage collaboratively with persons (and their families) identified at risk of harm.

Monitoring of the system is via incidents, clinical reviews, mortality and morbidity meetings, official visitor reports and patient feedback. At assessment a number of events had been reported and these had all been subject to a clinical system review and reported to the Clinical Incident Review Committee and Corporate Clinical Risk Manager. Actions arising from these had been implemented and include an increased awareness and reduction of access to environmental items for patients, who have been assessed at risk, antenatal assessments, daily environmental checking, patient search and modifications made to bathroom doors to reduce ligature points. Recommendations from the bi-annual workplace assessments (PERT audits) conducted in the mental health units have been progressively attended to.

Consumers and carers have been engaged at the direct care level.

The Work Health and Safety Committee provides operational oversight and implementation of the organisation's work place safety management system, and reports to the Workforce and Contracts Committee.

The recent formation of a working group to specifically address matters pertaining to patient related aggression, challenging behaviour management and the Code Black response has been beneficial in identifying and managing clinical risk and prevention strategies to this patient cohort.

The identification of potential aggressive and/or challenging behaviours are identified during pre-admission screening, at admission presentation, or through the episode of care and are flagged in WebPAS and the eMR. The eMR alert however, has limitations on the amount of information that can be sourced that describes the behaviour and any associated management plans at the point of care. These are accessible utilising other processes and there are plans in place to build in this capability within the eMR platform. Patients identified at risk of becoming aggressive or violent are specialled by suitably skilled security and nursing personnel. The geographical placement of persons 'at risk' in the clinical unit are considered in context of both clinical, patient experience and safety needs. Future planning suggests that a specific number of beds will be allocated to high risk persons with complex needs, with shared care between treating clinicians and this is to be encouraged.

Occupational Violence Alert (OVA) training is mandatory for all staff. Participation rates for the completion of the introductory online module - Wave 1 is at 90% of all staff. An OV training matrix has

been developed to identify additional training requirements for staff, depending on the risk assessments of their work place and role. Attendance rates for additional training are high and encouraged.

Occupational violence alert call buttons are located by the patient bedside and when activated trigger a Code Black call. The Code Black responder team is comprised of medical, nursing and security personnel whom have been specifically trained in Violence Prevention Management (VPM). Staff working in high risk areas are provided with personal duress alarms. Incidents relating to escalated behaviours are recorded as a Code Black. At the time of assessment around 30 Code Black events are triggered per month across the services.

Improvements to the system and associated processes have been strengthened through the use of formalised Code Black responders, rapid sedation guidelines and kits in the emergency department, patient search processes in mental health services, community mental care plans, and interdisciplinary and interagency behaviour management plans.

The summary takes into consideration the multiple layers of reporting and clinical governance arrangements (at both the state, corporate and local levels) that provide oversight to minimising restrictive practices for persons accessing mental health or acute services at NBH.

NSW health and NBH policy directives outline processes to treat patients without the use of restrictive practice, and to ensure that when used such practice is in accordance with legislation and reporting of such events. These have been made accessible to staff and supported with face-to-face education.

The Patient Care Review and Mental Health Quality and Safety Committees provide operational oversight and implementation of the hospital's restrictive practices prevention and management system. The Seclusion, Restraint and Absconding Committee has been convened to undertake clinical reviews and make recommendations on the management of reported restrictive practices and absconding events that occur within the mental health services. Two meetings have been conducted to date and minutes reflect the formative nature of this committee. The committee reports through to the Patient Care Review Committee.

Seclusion and mechanical restraint are not endorsed practices in the general health care setting. Physical restraint is utilised by trained staff only to enable the provision of therapeutic interventions under a treatment order, or where clinically appropriate. The system is monitored through local and state performance measures, incident analysis, and clinical reviews. Events are reported into the incident management system and reported in the restraint register. Reports are provided to State, NSLHD and NBH quality and safety committees. The restraint register is reviewed by the official visitors. Restrictive practice rates are benchmarked across the mental health services and ACHS clinical indicators. Trauma informed post incident conversations are conducted between staff, individuals and family members.

Staff working in the mental health services, emergency department and other high-risk clinical settings attend Violence Prevention Management training (VPM) which incorporates de-escalation techniques in addition to the application and management of physical restraint where clinically required.

Initiatives to decrease the use of restrictive practices were evidenced. At assessment equipment required to commission a low sensory stimulation room and additional exercise equipment were

endorsed. During assessment it was noted that some units have introduced components of the Safe Ward program.

Consumer and carers are provided information relating to restrictive practices in the consumer and carer guides.

Suggestions for Improvement:

Whilst the training for dementia and cognition management appears quite extensive, a suggestion has been made to formalise the education and training program for all staff, to support the system and also communicating with patients, carers and or their families to minimise anxiety or distress relating to their care.

Consider expanding the terms of reference of the Minimising Patient Harm Committee to incorporate self-harm and suicide within its mandate.

Develop an annualised action plan to respond to the elements incorporated in Actions 5.31 and 5.32, identified risks and operational objectives to provide structure and monitor progress across the mental health and general patient cohorts.

Formalise the organisation's education and training program for all staff to increase awareness and capability in the identification and management of persons at risk of self-harm or suicide.

The current working group reviewing practices associated with the Code Black be continued and re-framed to monitor and embed the safety elements incorporated within Action 5.33 – and 5.35d across the organisation, with linkages to the Minimising Harm Safety Committee.

Consider expanding the terms of reference and membership of the Seclusion, Restraint and Absconding Committee, so that matters pertaining to restrictive practices are applied across all care settings.

It is suggested that a clear restrictive practices minimisation action plan be developed to support a reduction in the use of restrictive practices utilised across all the clinical care units and increase compliance with processes described in the system.

Consider rolling out the Safe Ward program across mental health units and where appropriate high-risk acute units.

Suggest that current dietetic service provision across NBH is reviewed and that the service is redesigned to ensure that all consumers have access to a dietician when required.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

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

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

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

Assessment Team Summary:

There is evidence at NBH of systems in place to ensure timely, effective communication that supports continuing, coordinated and safe patient care. These systems are supported by executive leadership and a culture of patient-centred care. Communication for patient safety is well embedded in the Clinical Governance Framework. Recent examples of improvement in communication for patient safety include the excellent 'Perform' initiative, with clinical communication in the wards being monitored daily. Other examples include the roll out of KICK-T communication, various handover tools and REACH. There is a maturing culture of patient participation in care. This is visible during bedside handover, discharge planning, ward rounds in mental health service, ambulatory care visits including the wound clinic. Bedside handover in the mental health wards is innovative. Electronic patient journey boards are used to map the patient journey effectively and are strategically located to mitigate privacy risks.

There is a system in place to monitor and report the effectiveness of communication for patient safety. This includes observational audits of bedside handovers, patient experience surveys using Qualtrics, complaints management and audit of handover tools like SAFE. These are reported to the PCRC. The risk register includes matters relating to communication such as consumer feedback, clinical handover and discharge planning. In addition, incidents relating to communication are logged on RiskMan. A recent SAC1 event relating to patient identification, was investigated using interstate investigators. Well-being support for the patient and the two clinicians was provided during the open disclosure process.

There is a maturing culture of patient participation in care. This is visible during bedside handover, discharge planning, and in the ambulatory care environment. There is a determined intent to enable patients to be involved in communication about goals of their care. During assessment, the assessors observed that some patients were well prepared and had their question ready for the clinicians, using the patient care boards prompts.

NBH has a comprehensive policy framework to support patient identification and procedure matching. This includes communication at transitions of care, including ward transfers and discharges. A recent improvement arising from an incident investigation has resulted in the wards persons and nursing staff timeout processes to ensure the appropriate patient is being transferred for investigation. Discharge documentation is forwarded electronically to caring community doctors and teams, and includes content from laboratories, radiology and pharmacy as well as discharge instructions.

Regular huddles and ward rounds during each shift communicate critical information, including emerging clinical information. There is timely communication to the specialist medical staff whenever there is a deterioration or significant change in the patient's clinical status.

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:

Three identifiers are required at NBH to appropriately identify patients, and the assessment team confirmed that the checking of these identifiers and ID bands was embedded practice in all handovers and transition of care. ID bands are supplemented by photo IDs in mental health wards. There is a rigorous process for identification of newborns, including twins. However, the assessment team found there were occasional patients referred by bed number rather than by name in some staff station communications. There is a suggestion to reduce reliance on bed numbers when referring to patients in staff stations.

There are various team timeout processes to ensure that patient identification and procedure matching occurs. These timeout processes include surgical team timeout, ED resuscitation timeout, paediatric resuscitation timeout, wards persons timeout, ECT timeout and expressed breast milk (EBM) checking. Monitoring and reporting has demonstrated compliance with these processes.

Suggestions for Improvement:

Include patient UR number and the patient's ward as identifiers used in the Methadone register.

Appropriately identify patients by name rather than by bed number in staff station communications.

Suggest that NBH review the Expressed Breast Milk (EBM) storage and administration process, in light of best practice initiatives that have identified a safe option of a single lock and key storage system for consumers to store their own EBM. This system eliminates the risk involved in staff handling the consumer's EBM.

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:

There is a systematic approach to clinical handover using the ISBAR and KICK-T framework. Clinical handover eLearning is mandatory with 97% of staff compliant in this regard. Numerous clinical huddles were observed by the assessment team and these were found to enhance communication regarding the risks, alerts, ceilings and goals for each patient. Structured bedside handover occurs after the clinical huddles, and includes clinical progress, patient participation in reinforcing goals of care, as well as discharge planning and patient education. The patients were observed to be appreciative of the opportunity to ask questions and to participate.

There is an excellent structured clinical handover each morning for medical staff, which is led by a senior clinician and provides the opportunity to balance workload and supervision of the junior medical staff, as well as communicate the risk of changes in patient's clinical condition. All clinical reviews and codes are discussed.

The bedside clinical handover in mental health is innovative. The assessment team found that the ward huddle was structured to identify global risks, such as aggression or environmental risks, whereas the bedside handover focused on the client's symptoms rather than diagnoses, and actively engaged with the client. The assessment team was also aware of the client's consent to participate in bedside handover.

The results of monitoring of clinical handover is reported via the Minimising Harm Committee to the PCRC. There has been no negative feedback from patients about their participation in handover and no evidence of privacy breaches, using Qualtrics surveys or Incidents data from RiskMan.

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:

Critical information, alerts and risks are communicated in a timely way by the multidisciplinary teams. Specialist medical staff are primarily responsible for patient care and are notified whenever there is a change in the patient's condition. The Medical Orders for Life Sustaining Treatment (MOLST) tool documents ceilings of care in line with patient's wishes. In addition, pharmacists use the MMP to convey any risks arising from medications, so that the risks can be mitigated. Remote technology assists with communication of risks in obstetric cases. Other modalities include safety huddles, patient care boards, ward rounds, electric patient journey boards and family conferences.

Patients and carers can communicate and escalate their concerns via the recently launched REACH program. Patient care boards are updated daily and provide a forum for any questions or concerns. The assessment team noted that there have been no activations of REACH at the executive level.

Documentation of information

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

Assessment Team Summary:

Critical information, alerts and risks are contemporaneously documented both within the paper-based medical record, and the eMR. Care plans and risk assessments are revised and updated appropriately. In addition, third party providers like Pharmacy, Laboratories and Radiology contribute to the medical record in accordance with their agreement with NBH.

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:

Governance of this Standard is provided by the NBH Pathology and Transfusion Committee ('the Committee') with reporting up to the Patient Care Review Committee. Membership reflects the broad range of clinical services available at NBH including: Anaesthetics, Intensive Care, Maternity / Paediatrics, and Oncology and Transfusion, the latter being represented by a Clinical Nurse Consultant. The private practice laboratory located onsite ('the Laboratory') has a strong presence and voice, thus providing an integrated governance. Expert advice is available from the Clinical Haematologists and the assessors noted that available support has improved appropriately since the Interim Survey. The Committee meets appropriately, with the published committee calendar showing that 5 regular meetings were scheduled for 2019.

There are a mixture of Healthscope Corporate Office policies and local NBH policies. All policies related to this Standard are current and are based on best available evidence, such as national guidelines. Policies are covered in staff orientation sessions and manuals and are easily accessible to staff via the desktop icon. Additional information is provided in the junior doctor orientation.

Risks are recorded in RiskMan and managed accordingly. The assessors noted that the relevant risks currently registered for this Standard included: post-partum haemorrhage, inadequate management of blood and blood products, inadequate provision of information for informed consent for blood and blood products, and, incorrect administration of blood and blood products. All of these risks are currently assessed in the register as being stable, based on trends.

Educational information is available to relevant staff. All staff involved in blood management are required to undertake: online learning in ELMO Healthscope, eLearning available from the National Blood Authority 'Blood Safe', and, blood competency assessments (NBH currently has 88% compliance across the hospital, highest in the critical care areas). A Blood Resource Folder is available in the clinical areas, with resources including: a 'Flippin' blood guide, a General Guide to Blood Transfusion, a Parents' Guide to Blood Transfusion, and, related information in various languages. Posters are on display in the relevant clinical areas.

The Committee Minutes were reviewed by the assessors and it was evident that risks, incidents, adverse events and opportunities for improvements were considered regularly.

Performance was also assessed by regular auditing, that was undertaken as per the NBH Audit Schedule. Performance results were reported back to the workforce in NBH Staff Newsletters, VMO Newsletter from the Director Medical Services, departmental meetings, and, in quality / performance boards in the clinical areas. NBH reports KPI data to Healthscope and reports Clinical Indicator data to ACHS.

Some notable strategies for improvement that have been undertaken include: implementation of Thromboelastometry (ROTEM) and of Massive Blood Transfusion Protocol.

NBH provides consumers with a Patient Information Directory and leaflets to meet their information needs. Interpreters are provided as required. Support contact details are made available to clinicians for when they need assistance when managing Jehovah Witnesses, other patients and patients reluctant or unwilling to receive blood and blood products (e.g. cultural beliefs), in relation to discussions on: what they will and won't accept, what alternatives are available, and, what risk mitigation strategies can be put in place. Where possible this is done on a pre-admission basis. Staff are aware that in emergencies (where patients might not be able to communicate), patients' wishes can be elicited from advance care directives, or failing that, from patients, carers or family. Staff are also aware of special processes that need to be considered in the case of children who may require transfusion as a life-saving intervention.

An audit of consent was recently undertaken, which showed compliance being below target in relation to 'tick the blood products' box as part of the general consent to treatment on admission. It was noted by the assessors that this was separate from the specific consent for administration of blood and blood products, where compliance was within target. Education will be increased in 2020 and a re-audit will be undertaken.

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:

NBH optimises patients' own blood status by offering oral or intravenous iron replacement where necessary (e.g. anaemia) and where time permits. This is usually undertaken in the Infusion Centre. The assessors noted that IV Immunoglobulins and blood may also be administered in the Centre. Consent for infusions here is generally valid for 12 months.

Transfusion also tends to occur in the: Interventional (Theatre) Suite, ICU, on route to or from these clinical areas, Critical Care and Maternity.

Patients at risk of reactions, such as maternity patients, are screened antenatally.

The assessors noted that NBH was not a designated Major Trauma Centre, although less serious trauma may present, along with (potentially) patients requiring immediate life-saving emergency stabilisation.

Blood Management processes are not carried out in Mental Health clinical areas.

Patients at risk of bleeding are identified by taking a transfusion history (from patients, carers, family, flagged alerts, or WebPAS), medication history, clinical assessment and investigations as required. The medication, Tranexamic Acid, is available to clinicians to limit bleeding if required. A Cell Saver is available for use in the Interventional Suite, the use of which is being encouraged where appropriate.

The improvement entailing the introduction of ROTEM into NBH has reduced inappropriate use of blood and blood products, in the case of the bleeding patient. The assessors noted that NBH and the Laboratory operate on a 'release one unit,' then review before release of further units' basis.

When blood or blood products are deemed necessary for a patient, the clinician completes a request form, which is labelled and sent off to the Laboratory. Any mislabelled specimens are returned, and re-collection is required. Although NBH has had some near misses in this regard, there have not been any actual clinical incidents. Unusual requests are reviewed by the Laboratory and discussed with the Haematologist, who may discuss with the requesting clinician where appropriate.

NBH uses a Blood and Blood Products Prescription and Transfusion Record, which includes checklists for 6 'rights': right to transfuse, right documentation pre-transfusion, right patient, right blood product, right pack, and, right time. The assessors noted that NBH and the Laboratory operate on a 'group and hold' first, before requesting cross-match' basis, where clinically appropriate.

Use of these processes is part of the NBH Audit Schedule, and the results considered by the Committee and reported as required.

Adverse events are appropriately managed and communicated as required. Staff involved in blood administration know to stop the transfusion process if there is anything unusual with the product or if an adverse event occurs. In addition to clinically managing the patient (including observations, review, blood samples for investigation, antibiotics if indicated, advice to patient, record in RiskMan and discharge summary), staff know to return the product to the Laboratory for further investigation (e.g. microbiology testing) and reporting. It should be noted that whilst there have been some incidents and events reported, there have been no serious incidents in relation to this Standard at NBH.

The Oncology and Transfusion Clinical Nurse Consultant and identified Blood Champions in the relevant clinical areas provide support for these processes.

NBH aims to limit transfusions and infusions are to be completed by 5pm, unless clinically needed. An After-Hours Manager has oversight of these processes that need to take place after-hours.

Suggestions for Improvement:

A review to support availability and the use of iron infusion that are clinically preferable in most situations, such as, short infusion time, low fluid volume and less risk of adverse reaction be considered.

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:

NBH works within manufacturers', legislative and jurisdictional requirements, in relation to this Standard.

The assessors confirmed that the Laboratory is NATA Accredited, and is preparing for an imminent re-accreditation process.

The sole Blood Fridge onsite is located within the Laboratory and is only accessed by Laboratory staff. Fridge monitoring is overseen by Laboratory staff. Unused product is not accepted back into the Blood Fridge, but instead is returned to Blood Bank as wastage for disposal.

The assessors observed processes in real time where blood was being transported within the hospital (for example from the Laboratory to the Interventional Suite). The assessors noted the good knowledge and performance of the Wards persons undertaking this task in relation with working with the clinical staff to document the movements and also to provide 'ASAP' transport within required time limits. It was also noted that some aspects of traceability were electronically recorded whilst some were still paper-based.

NBH aims for 0% wastage of blood and blood products, which was reportedly achieved in the month of Oct 2019. Where wastage occurs at NBH, it is mainly with platelets.

The Laboratory provides a 24 hours service, 7 days a week. There is reportedly good communication between stakeholders, such as clinicians and the Blood Bank, in times of high demand or shortage of product. An urgent courier service from Blood Bank to NBH is available.

Suggestions for Improvement:

Investigate whether there are now suitable electronic system options that would increase electronic recording and traceability across the whole pathway.

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:

Oversight and Governance of this Standard is provided by the Clinical Emergency Response Systems (CERS) Committee, with reporting up to the Patient Care Review Committee (PCRC).

Membership reflects the broad range of clinical services available at NBH and the available expertise, including: Intensive Care, Birthing / Maternity, Critical Care, Medical, Emergency Department, Mental Health, Paediatrics, Anaesthesia and Education Services. The Committee meets monthly.

There are a mixture of Healthscope Corporate Office policies and local NBH policies. All policies related to this Standard are current and are based on best available evidence.

Risks are entered into RiskMan and managed accordingly. The assessors noted that the relevant risks currently registered for this Standard included: post-partum haemorrhage, basic life support – VMOs not fully trained by hospital, inadequately managed paediatric resuscitation, inadequate management of deteriorating patient in Mental Health, requiring scheduling under Mental Health Act, inadequately managed neonatal resuscitation, inadequately managed code blue call, delay or failure to call code blue, delay in emergency caesarean section. All of these risks are currently assessed in the register as being stable, based on trends.

Basic Life Support (adult) training is currently running at 82% for online and 89% for competency. Advanced life Support (adult) training is currently running at 72%. Advanced life Support (paediatric) training is currently running at 100%. Advanced life Support (newborn) training is currently running at 100%. The assessors had the opportunity to observe a Simulation Training exercise in relation to this Standard, in the Simulation Centre. It was noted that such sessions are also held in the ICU.

NBH reports KPI data to Healthscope and reports Clinical Indicator data to ACHS. The CERS Committee produces a monthly CERS Report for the PCRC.

Some notable strategies for improvement that have been undertaken include: appointment of a dedicated CERS Coordinator, a dedicated paging system, a new 3 tiered response system rolled out across adult and then maternity and paediatrics (with the assessors having the opportunity to run through the development, implementation and refinement of this model using the PICMORS methodology, with CERS Committee members), and the use of the Confusion Assessment Method (CAM) in ICU.

NBH uses Comprehensive Care Planning, Alerts on eMR, Informed Consent, My Care Board, Medical Orders for Life-Sustaining Treatment (MOLST) to be consistent with current Advance Care Directives (where available), Last Days of Life Care and Management, End-of-Life Care, and REACH (Recognise, Engage, Act, Call, Help) processes to partner with consumers in decision-making in relation to this Standard.

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:

For the Emergency Department, NBH has implemented a formal nurse triaging system, which is a front of house waiting room emergency nursing model. The assessors had the opportunity to run through the development, implementation and refinement of this model using the PICMORS methodology, with the NBH CNCs.

NBH uses a standard set of track and trigger forms, for different clinical scenarios and different age groups. These forms mostly incorporate a yellow and a red zone within a graphical format. Observations are set according to patients' Care Plans. The graphical format allows trends to be easily observed.

Nursing staff may use the tools to initiate a clinical review, a rapid response or a Code Blue, as appropriate.

For recognising deterioration in mental health, NBH uses the 4AT tool for assessment of delirium and the CAM tool in ICU. The assessors had the opportunity of discussing with the Acute Pain Management team, the challenges in assessing cognitive dysfunction after surgery, separating temporary anaesthetic effects, from pain, from delirium.

NBH has met Advisory AS19/01progress requirements in relation to this Criterion.

The REACH program has been implemented to allow for patients, carers or families to directly escalate care, if existing internal actions do not resolve the concerns, but NBH advised the assessors that it had not yet been used, despite posters being highly visible in all clinical areas.

NBH provides a dedicated paging system to the workforce to receive and make escalation calls for assistance. There are also nurse call and emergency alarms by the patients' bedside.

Each morning, the ICU review all patients who had a CERS call during the previous after-hours period and maintain an Outreach Ward Round Record and an Emergency Response Data Collection.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

NBH uses a 3-tiered response system, for timely response by clinicians, whose skills are ensured through a mandatory training and competency assessment.

The training profile for life support in adults, paediatrics, and newborn allows for appropriate rostering of staff on the wards and on the emergency response teams, so as to have assistance available to manage acute physiological deterioration on a 24hr 7 days a week basis, either on-site or sleeping over, or proximate on-call.

Processes are in place for the Emergency Department and general clinical areas to refer acutely deteriorating Mental Health patients for mental health management within NBH. This can be either by, in unit presence, Consultation Liaison, admission to Mental Health Wards (or both). NBH has met Advisory AS19/01 progress requirements in relation to this Criterion.

Processes for rapid escalation and transfer to other hospitals of patients with deteriorating physical or mental health, are available if needed. For most adult cases this would be to Royal North Shore Hospital and for most children this would be to the Sydney Children's Hospital Network. For Special Care Nursery patients this would be via the Neonatal and Paediatric Transport Service (NETS).

The assessors were shown the state-of-the-art Helipad at NBH.

National Standards for Mental Health Services

Assessment Overview

The NSMHS were assessed concurrently with the NSQHS Standards (2nd Ed.) accreditation assessment. All NSMHS criteria were assessed as Met.

Assessor Summary comments are noted under the appropriate criterion groupings for each Standard

STANDARD 1 Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care.

Assessor Summary

Treatment in Least Restrictive Environment

Persons accessing the Northern Beaches Hospital Mental Health (NBHMH) services have care delivered in the least restrictive environment. The facility provides open spaces for therapeutic and socialising activities, and the provision of ensuite bedrooms that provide privacy. Natural light and fresh air are promoted. Persons have access to common areas as required. The identification and removal of potential environmental harm risks such as ligature points and reducing access to unsecured heights increases safety. Policy and procedural guidelines describe care principles for persons admitted into the services. Consumers are accommodated in the most appropriate ward setting that best meets their clinical needs. Rights and responsibilities of persons are visible within all the units and consumer/carer publications and staff are made aware of these at orientation and throughout their employment. Leave approval processes, coupled with the IMATIS leave management system, support and monitor consumers with approved leave.

Access to Staff of Own Gender

Healthscope (Corporate) and NBH policy and procedures describe a person-centred approach to care which includes reference to meeting needs and expectations. Staff rosters are developed to ensure there is an appropriate gender mix for each shift. Neither feedback from consumers/carers within the service or the Official Visitors have raised this as a concern.

Advocacy and Support

NBH policies such as Partnering with Consumers make specific reference to advocacy and support. Official Visitors visit the units monthly and findings are documented and responded to. It is suggested that the Official Visitor reports be incorporated into the NBH feedback system to give increased visibility of matters raised. Consumers and carers are advised of advocacy and support options in the NBHMH consumer and carer guides and Northern Beaches Discharge Planning and Resources workbook. Peer workers (consumer consultants) have also been engaged to support persons in the inpatient units.

Criterion 1.8

The MHS upholds the right of the consumer to have their privacy and confidentiality recognised and maintained to the extent that it does not impose serious risk to the consumer or others.

Assessor's Rating	Met

Criterion 1.9

The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.

Assessor's Rating	Met

Criterion 1.13

The MHS upholds the right of consumers to have access to their own health records in accordance with relevant Commonwealth, state / territory legislation.

Assessor's Rating	Met

Criterion 1.15

The MHS upholds the right of the consumer to access advocacy and support services.

Assessor's Rating	Met

Criterion 1.17

The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.

Assessor's Rating	Met

STANDARD 2 Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Assessor Summary

Protection from Abuse and Exploitation

Multiple NBH policies describe practices and principles to mitigate abuse and exploitation of persons accommodated within the inpatient and emergency care settings. Specific policies such as those pertaining to consumer searches (belongings and self) and sexual safety of persons accommodated within the mental health service seek to address matters of physical safety. Staff are made aware of these documents on appointment to the unit. Consumer and carer handbooks have been developed to provide clarity around these matters to consumers and carers. Persons with capacity sign an inpatient mental health agreement on admission. The design and refurbishment of a specific area to facilitate patient search on return from leave is a notable improvement both in terms of increasing safety whilst preserving the consumer's dignity

Reduction/Elimination of Restraint and Seclusion

NSW Health and NBH policy directives outline processes to treat patients without the use of restrictive practice, and to ensure that when used such practice is in accordance with legislation and reporting of such events. These have been made accessible to staff and supported with face to face education.
The Patient Care Review and Mental Health Quality and Safety Committee provide operational oversight and implementation of the hospital's restrictive practices prevention and management system. The Seclusion, Restraint and Absconding Committee has been convened to undertake clinical reviews and make recommendations on the management of reported restrictive practices and absconding events that occur within the mental health services. Two meetings have been conducted to date and minutes reflect the formative nature of this committee. The committee reports through to the Patient Care Review Committee.

It is suggested that a clear restrictive practices minimisation action plan be developed to support a reduction in the use of restrictive practices utilised across all the clinical care units and increase compliance with processes described in the system.

Physical restraint is utilised by trained staff only to enable the provision of therapeutic interventions under a treatment order, or where clinically appropriate. The system is monitored through local and state performance measures, incident analysis, and clinical reviews. Events are reported into the incident management system and in the restraint register. Reports are provided to State, NSLHD and NBH quality and safety committees. The restraint register is reviewed by the Official Visitors. Restrictive practice rates are benchmarked across the mental health services and ACHS clinical indicators. Trauma informed post incident conversations are conducted between staff, individuals and family members.

Initiatives to decrease the use of restrictive practices were evidenced. At assessment equipment required to commission a low sensory stimulation room and additional exercise equipment were endorsed. During assessment it was noted that some units have introduced components of the Safe Ward program and it is suggested that the organisation give consideration to rolling out this initiative across all mental health units.

Refer NSQHS Standard 5 minimising restrictive practices criterion summary 5.35 - 5.36.

Compliance with Current National/State Safe Transport Principles
NBH has a suite of policy documents that describes the practices associated with the transport of patients both within and across health services. These are in accordance with the National Safe Transport principles April 2008. Memoranda of understanding with both the NSW Health and NSW Police and Emergency Services - mental health were sighted. Incidents relating to transport are reported via the incident management system and discussed at the Northern Beaches interagency committee if appropriate.

Criterion 2.1

The MHS promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.

Assessor's Rating	Met

Criterion 2.5

The MHS complies with relevant Commonwealth and state / territory transport policies and guidelines, including the current National Safe Transport Principles.

Assessor's Rating	Met

STANDARD 3 Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

Assessor Summary

Consumers Right to Independent Representation

A range of policy documents and associated forms provides a structured approach to ensure that a consumer's right to independent representation occurs and is documented. Consumers have the right to independent representation, and this is promoted at point of entry into the service. The admission procedure requires consumers to complete a 'Nominated of designated carer'(s) form. Primary carer documentation audits indicate 100% compliance with the completion of the form. Information flowing from this form is recorded into the electronic patient administration systems and communicated to the clinical workforce. Consumer awareness posters, patient information guides and brochures relating to rights and responsibilities, legal aid and advocacy were visible in clinical units. A consumer survey conducted in August/Sept 2019 indicated that 86% of participating consumers know and understand their rights.

Consumer Representation to the MHS

Consumer participation is evolving within MHS with a consumer consultant (peer worker) engaged across the services. Two peer workers (one FTE) have recently been appointed and have completed the training to undertake their role. These roles report through to the Allied Health Team Manager and are provided with supervision and support. Peer workers facilitate weekly consumer meetings and feedback provided is actioned and has led to improvements in the daily therapy programs and physical environments. Consumers are actively engaged at corporate, hospital and service levels with representation on a range of committees. The NSW Health YES survey for mental health consumers is actively promoted across units. Whilst the response rate is low feedback provided is actioned and displayed across the unit. Bedside clinical handover, whilst in its infancy, provides the opportunity for a contemporaneous conversation with consumers who are actively engaged in their care. NBH complaints management process also provides a more formal mechanism for feedback. All staff have undertaken online training in person-centred and recovery-based care. This has been well represented in Standard 2 of the National Safety and Quality Health Service Standards which were assessed concurrently.

Criterion 3.4

Consumers and carers have the right to independently determine who will represent their views to the MHS.

Assessor's Rating	Met

Criterion 3.6

Where the MHS employs consumers and carers, the MHS is responsible for ensuring mentoring and supervision is provided.

Assessor's Rating	Met

Criterion 3.7

The MHS has policies and procedures to assist consumers and carers to participate in the relevant committees, including payment (direct or in-kind) and / or reimbursement of expenses when formally engaged in activities undertaken for the MHS.

Assessor's Rating	Met

STANDARD 4 Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Assessor Summary

MHS Identification of its Communities Diverse Population

Healthscope policies on Diversity, Inclusion and Gender Identity are utilised by NBH, however they have also created local NBH policies on CALD populations, Interpreter and Pastoral Care Services.

NBH reviews its diversity and service profile annually and publishes the data in the annual report. Current data suggests that the majority of patients self-reporting are Australian with the UK and New Zealand being the highest ethnic groups. 94.32% report speaking English as their first language. Where English is a person's second language translation and interpreter services are readily available. The use of these services is reported and monitored. Usage is low.

Processes have been implemented to ensure all ATSI persons are identified at point of entry into the clinical and administrative datasets within the electronic systems. Persons identified are to be flagged in the specific service's patient management system and in the eMR; however reports have yet to be generated to routinely measure compliance with the process and the numbers of unstated classifications.

This is further addressed in Standard 2 Action 2.8. 68% of staff have completed "asking the question" training.

Refer NSQHS Standard 1 Governance Criterion 1.15 diversity and hig- risk groups summary.

Utilisation of Data to Review and Communicate to Staff

A recent demographic audit of persons who had accessed mental health services at NBHMH indicated that 1% self-declared as indigenous. Whilst access to a corporate indigenous consultant is available NBH has identified the need for a site-based NBH indigenous consultant. Progress to appointment was evidenced during the survey. NBH has been able to identify the three main CALD populations which access services and a range of hospital strategies to support and communicate with persons in care is available to the mental health service.

Engagement with Service Providers with Diversity Expertise

The clinical workforce has access to a range of specialist services and agencies to provide support for persons with diverse needs through the Northern Beaches interagency MH forum. The forum has produced a mental health resource booklet listing all local agencies, the services that they provide and principal contact. Health professionals working within the service are also representative of the community and are able to provide cultural support and orientation where appropriate.

Addressing Issues of Prejudice, Bias and Discrimination

Corporate human resource policy and procedures describe the expectations of the clinical workforce in providing care to consumers and carers of its services. Role descriptions and code of conduct address matters of prejudice, discrimination, bullying and bias. Staff indicate their understanding and agreement to practise within these frameworks on appointment. The performance management system is utilised to monitor and influence behaviours where appropriate. Cultural surveys measure staff experience within the workplace.

Equitable Access to Services
Access to mental health services is accessed according to clinical need and the organisation's capacity to provide the service. Processes are in place to ensure that patients are accommodated into the appropriate care setting that best meets their needs. Patient flow activities adopt a person-centred approach and are focused on placing patients in the right bed the first time in a timely manner. MHS models of care describe the service offering of each of its units and exclusion criteria where they exist. There is capacity within the model of care to escalate to the executive where access to a service is questionable.

Criterion 4.4

The MHS has demonstrated knowledge of and engagement with other service providers or organisations with diversity expertise / programs relevant to the unique needs of its community.

Assessor's Rating	Met

Criterion 4.5

Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.

Assessor's Rating	Met

Criterion 4.6

The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure non-discriminatory practices and equitable access to services.

Assessor's Rating	Met

STANDARD 5 Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

Assessor Summary

Promotion/Prevention of Mental Health Problems and Illness

NBHMH has recently commissioned a small MH promotion and prevention working party with the responsibility of developing, implementing and evaluating NBHMH promotion activities. Draft terms of reference were sighted, and a Health Promotion and Prevention Action Plan developed. This forum is in its infancy. Whilst the development and outcomes of the plan were broadly communicated it was unclear which governance committee this reported/linked into. It is suggested that this be clarified to ensure unity of purpose, ongoing monitoring and appropriateness.

Consumers/Carers Activities to Promote Health and Wellbeing

Consumers and carers are engaged in activities to promote health and wellbeing principally through the unit's therapeutic program. Group activities have a range of topics that discuss self-care. Examples include walking, gym activities, and dietary advice, and music and art therapies. Smoking cessation assistance is offered. Consumers are provided with a discharge and resources work book which encourages them to identify activities that are helpful in maintaining their wellbeing. These initiatives have yet to be evaluated in terms of meeting the needs of consumers/carers.

Co-ordination of Promotion/Prevention Activities

The service actively participates in the community interagency mental health promotional activities which include the Narrabeen markets, wellness walks, and the October mental health awareness week.

Staff Education to Support Promotion/Prevention Principles

Activities undertaken to date include in-service training as part of the calendar of training events on mental health promotion and prevention within the units and utilising the NBH newsletter to inform and promote mental health services across the hospital. The NBH Workforce unit also supports and promotes initiatives to support staff wellness, which includes access to the EAP services in addition to supporting national mental health initiatives such as RU OK days.

Criterion 5.1

The MHS develops strategies appropriate to the needs of its community to promote mental health and address early identification and prevention of mental health problems and / or mental illness that are responsive to the needs of its community, by establishing and sustaining partnerships with consumers, carers, other service providers and relevant stakeholders.

Assessor's Rating	Met

Criterion 5.2

The MHS develops implementation plans to undertake promotion and prevention activities, which include the prioritisation of the needs of its community and the identification of resources required for implementation, in consultation with their partners.

Assessor's Rating	Met

Criterion 5.3

The MHS, in partnership with other sectors and settings supports the inclusion of mental health consumers and carers in strategies and activities that aim to promote health and wellbeing.

Assessor's Rating	Met

Criterion 5.4

The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.

Assessor's Rating	Met

Criterion 5.5

The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities.

Assessor's Rating	Met

Criterion 5.6

The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.

Assessor's Rating	Met

STANDARD 7 Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Assessor Summary

Prompt Identification of Carers/Refusal to Nominate a Carer

Corporate and NBH policy documents describe the process by which staff can effectively identify carers as soon as possible, in addition to the management of persons who refuse to provide such information. These documents make reference to the appropriate legislation. Admission procedures require consumers to complete a "Nomination of designated carer"(s) form. Consumers can modify this form when required. Primary carer documentation audits indicate 100% compliance with the completion of the form. Information flowing from this form is recorded into the electronic patient administration systems, located in the clinical record and communicated to the clinical workforce. Conversations with consumers who refuse to nominate a carer are documented within the clinical record.

Special Needs of Children and the Aged as Carers

The needs of children and aged persons as carers are considered in the corporate and NBH procedural framework. Where persons are identified they are referred to members of the allied health team with follow-up support provided by specialist agencies. Established pathways of referral to children of persons with mental illness (COPMI) and the association of relatives and friends of the mentally ill (ARAFMI) were evidenced. There was little data presented during the assessment of the numbers of referrals made and the carers experience with the agencies in terms of appropriateness, access and support services offered.

Provision of Information to Carers

Carers are actively engaged in the service. Corporate and NBH policy documents describe the processes of consumer carer participation. Carer rights and responsibilities are clearly explained to them at the primary contact with the service and followed up with the recently released NBH carers' information guide and carers' wellbeing booklet. The NBH website provides additional information for carers interacting with mental health services. A carer's support forum was facilitated by the consumer consultants at which the carer information guide and survival kit were presented. No issues of concern were identified. Clinical information provided to carers is governed by corporate privacy and confidentially policies. No breaches had been reported at assessment. YES surveys suggest an improvement in overall satisfaction of carers with services and information provided.

Active Identification of Carers in Relapse Prevention Plans

Carer involvement across the care continuum is documented in the clinical record and Mental Health comprehensive care plan. Where a change to a consumer's condition occurs, carers are engaged where appropriate. A recent audit targeting Carer Involvement in Care demonstrated that 97.3% of carers were engaged in care discussions at the initial assessment and throughout the care continuum. The NBH discharge planning and resource workbook incorporates a section on relapse prevention and early warning signs. Carers actively participate in the discharge planning process. The booklet has only recently been released so is yet to be evaluated in terms of utility and effectiveness. The NBH REACH (consumer/carer escalation of care) program is promoted throughout the mental health service.

Criterion 7.1

The MHS has clear policies and service delivery protocols to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.

Assessor's Rating	Met

Criterion 7.3

In circumstances where a consumer refuses to nominate their carer(s), the MHS reviews this status at regular intervals during the episode of care in accordance with Commonwealth and state / territory jurisdictional and legislative requirements.

Assessor's Rating	Met

Criterion 7.5

The MHS considers the needs of carers in relation to Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.

Assessor's Rating	Met

Criterion 7.6

The MHS considers the special needs of children and aged persons as carers and makes appropriate arrangements for their support.

Assessor's Rating	Met

Criterion 7.7

The MHS has documented policies and procedures for clinical practice in accordance with Commonwealth, state / territory privacy legislation and guidelines that address the issue of sharing confidential information with carers.

Assessor's Rating	Met

Criterion 7.8

The MHS ensures information regarding identified carers is accurately recorded in the consumer's health record and reviewed on a regular basis.

Assessor's Rating	Met

Criterion 7.9

The MHS provides carers with non-personal information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation.

Assessor's Rating	Met

Criterion 7.11

The MHS actively encourages routine identification of carers in the development of relapse prevention plans.

Assessor's Rating	Met

Criterion 7.13

The MHS provides information about and facilitates access to services that maximise the wellbeing of carers.

Assessor's Rating	Met

Criterion 7.14

The MHS actively seeks participation of carers in the policy development, planning, delivery and evaluation of services to optimise outcomes for consumers.

Assessor's Rating	Met

Criterion 7.15

The MHS provides ongoing training and support to carers who participate in representational and advocacy roles.

Assessor's Rating	Met

Criterion 7.17

The MHS has documented policies and procedures for working with carers.

Assessor's Rating	Met

STANDARD 8 Governance, leadership and management

The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Assessor Summary

Promotion/Early Identification/ Prevention of Mental Health Illness

NBHMH has recently commissioned a MH promotion and prevention working party with the responsibility of developing, implementing and evaluating NBHMH mental health promotional activities. Draft terms of reference were sighted, and a Health Promotion and Prevention Action Plan developed. This forum is in its infancy. Whilst the development and outcomes of the plan were broadly communicated it was unclear which governance committee this reported/linked into. It is suggested that this be clarified to ensure unity of purpose, ongoing monitoring and appropriateness. The NBH works closely with the Northern Beaches interagency in health promotion, early intervention initiatives for the broader community

Position/s for Implementation of Promotion and Prevention Strategies

The chair of the MH promotion and prevention working party is the nominated position responsible for the implementation of the MHS promotion and prevention strategies.

Budget and Adequate Resource Planning

Budget and resource allocation is established and reviewed annually. Consideration is given to achieving activity and patient safety and quality performance targets. The annual Mental Health Services strategic plan is developed by the MHS and endorsed by the executive. Activities listed in the plan are then funded and resourced accordingly.

Criterion 8.1

The governance of the MHS ensures that its services are integrated and coordinated with other services to optimise continuity of effective care for its consumers and carers.

Assessor's Rating	Met

Criterion 8.2

The MHS has processes to ensure accountability for developing strategies to promote mental health and address early identification and prevention of mental health problems and / or mental illness.

Assessor's Rating	Met

Criterion 8.5

Identified resources are allocated to support the documented priorities of the MHS.

Assessor's Rating	Met

Criterion 8.8

The MHS has a policy and process to support staff during and after critical incidents.

Assessor's Rating	Met

STANDARD 9 Integration

The MHS collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Assessor Summary

Facilitation of Care Co-ordination

Clinicians use processes for shared care decision making to develop and document a comprehensive and individualised care plan. Care planning is based upon the assessment of the consumer and is recorded in a care plan, program of care, progress note, or goals of care plan. A case management approach is adopted for persons with complex needs or who have an extended length of stay. Throughout the assessment period it was noticeable that consumers are actively engaged in their care.

Care is delivered in accordance with the MH care plan. The recently developed NBH Comprehensive Care Policy articulates the key components of an individualised care plan and staff responsibility to provide such care in partnership with consumers and their carers. Both the eMR and paper-based clinical records demonstrate changes to care plans in response to diagnostics, harm prevention plans, therapeutic interventions and goals of care. Such changes are made in real time and communicated to the clinical workforce.

Bedside clinical handover and Patient Boards provide opportunities for interactive contemporaneous conversations between consumers/carers and staff to ensure care goals are appropriate. Quality assurance methodologies such as clinical reviews, incident and complaint analysis monitor compliance with the system and clinical outcomes.

Refer NSQHS Standard 5 Comprehensive care Action 5.7 summary.

Interdisciplinary Care Teams

Multidisciplinary collaboration and team work are actively supported and evidenced across the service. Activities such as multidisciplinary huddles, structured clinical handovers, multidisciplinary meetings, case conferences, and safety huddles collectively work together to build and strengthen a strong team approach to the provision of comprehensive shared care.

Refer NSQHS Standard 5 Comprehensive care

Inter-Agency, Intersectoral Links and Collaboration

Discharge planning is commenced on admission and includes documentation of the consumer's expected length of stay, discharge destination and referral to additional discharge support services as required. Discharge is actively managed across the care continuum.

The referral system is supportive and responsive to the assessment process. The use of the eMR has improved the internal referral process between services, clinicians and community support agencies. Individual services/programs have a suite of formal referral pathways and prioritisation matrices. Consumers and carers accessing the mental health service are provided information on additional community resources available through a range of published booklets and guides.

Refer NSQHS Standard 5 Comprehensive care Action 5.13.

Criterion 9.4

The MHS establishes links with the consumers' nominated primary health care provider and has procedures to facilitate and review internal and external referral processes.

Assessor's Rating	Met

Criterion 9.5

The MHS has formal processes to develop inter-agency and intersectoral links and collaboration.

Assessor's Rating	Met

STANDARD 10 Delivery of Care

Assessor Summary

Access/Prioritisation/Inclusion/Exclusion Criteria

NBH Mental Health models of care describe the services provided to consumers accessing the older persons unit, acute service, emergency, short stay and the consultant liaison service. These are very descriptive documents which make reference to access, prioritisation, inclusion and exclusion arrangements. Within the documents there is provision to escalate events to the Executive when consumers who require a service may not align to the access criteria. Records of these conversations were not sighted at survey and it is suggested that a system be developed to record such conversations. The models of care have yet to be fully evaluated for their utility and compliance. The NBH risk register lists the accommodation of adolescent populations in adult care units as an open risk.

Assessment/Risk Assessment

The clinical and psychosocial risk screening and assessment process commences prior to and at point of entry into the service. Reassessment occurs at predetermined intervals. Screening is undertaken utilising a suite of tools, whereby a positive response links to a secondary assessment. Assessments are structured, multidisciplinary and information generated from the assessment is communicated to members of the clinical workforce through a range of clinical handover methodologies and documentation approaches. Elements of the process are individually evaluated utilising a series of quality assurance methodologies. The results of these are reported and actioned at a range of committees and working groups across the organisation. These processes are well established for falls, self-harm/suicide, pressure injury and nutrition and in the developmental phase for delirium /dementia, end of life, aggression and violence.

Refer NSQHS Standard 5 Comprehensive care Action 5.4 summary.

Informed Consent

NBH has well-established governance frameworks in place to ensure that its informed consent processes comply with legislation and best practice.

Procedural consent is governed under state and Healthscope policy directives and guidelines. ECT audits demonstrate 100% compliance with ECT. Incidents are low. Interpreters are utilised where required. Procedural guidelines describe the process by which financial consent is obtained across the organisation including the MHS. The financial consent process and forms meet the requirements as articulated in the *ACSQHC advisory AS18/10 Informed financial consent for chargeable patients in a public facility.* The consumer's financial classification is determined at or during the early admission phase to an inpatient unit by the administration service.

The clinical workforce is well supported to ensure that they are able to identify a consumer's capacity to make decisions about their own care and to identify a substitute decision maker if required. Documents within the system describe the process for capacity assessment, substitute decision makers and the provisions by which health services can be delivered to persons without their informed consent in specific circumstances.

Substitute decision makers, nominated persons with power of attorney, next of kin and advocates are recorded in the health care record, and updated across the care continuum.

The system is monitored through feedback provided by the Official Visitors and peer workers, incidents and complaints, and health record audits. The rate of incidents is low.

Refer NSQHS Standard 2 partnering with consumers; Criterion 2.4 -2.5 summary

Active Promotion of Recovery Oriented Values/Principles
Shared decision making is embodied into the care processes adopted by the MHS through the use of recovery orientated models of care across the care continuum.

The MH Care Plan/Consumer Wellness Plan is used to document issues identified at assessment and review, which need to be addressed during the consumer's episode of care. New goals can be added to the document and interventions can be updated. A copy of the plan can be given to the consumer. The MH progress note is used to document the consumer's progress against the interventions identified in the MH Care Plan/Consumer Wellness Plan. Compliance with the system is monitored through a series of scheduled and ad hoc clinical record audits and the results reported through to various committees. Compliance is variable and action is taken to address areas of concerns.

Bedside handover utilises a recovery-based structured conversation that staff and consumers/carers are able to engage in.

MHS Knowledge of Community Services/Referral to Community Services
The clinical liaison team has the primary responsibility of care coordination for persons across the care continuum and back into the community. The MH unit services directory coupled with the service linkage directory provide ready access to information on access and referral contacts for key agencies. Throughout the assessment period clinical staff were able to articulate the referral pathways for consumers to access community services.

Re-entry to the MHS - Facilitation/Ease of Access
Admission to the inpatient units is either through an emergency or planned presentation. Planned admissions are accepted from general practitioners, community mental health case managers, and the acute care team of private psychiatrists from Brookvale. Access back into the service is appropriate and where clinically appropriate direct admission to an inpatient mental health unit can be accommodated. Consumers/carers are provided with a copy of the consumer endorsed patient information handout on re-entering the MHS on discharge. Readmission rates for the NBHMH were not sighted during the assessment.

Post Discharge Follow-up
This is undertaken by the clinical liaison team. All persons discharged to the community are followed up within seven days.

STANDARD 10.1 Supporting recovery

Criterion 10.1.1

The MHS actively supports and promotes recovery-oriented values and principles in its policies and practices.

Assessor's Rating	Met

Criterion 10.1.3

The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.

Assessor's Rating	Met

Criterion 10.1.4

The MHS encourages and supports the self-determination and autonomy of consumers and carers.

Assessor's Rating	Met

Criterion 10.1.5

The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.

Assessor's Rating	Met

Criterion 10.1.7

The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.

Assessor's Rating	Met

Criterion 10.1.9

The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.

Assessor's Rating	Met

Criterion 10.1.10

The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

Assessor's Rating	Met

STANDARD 10.2 Access

The MHS is accessible to the individual and meets the needs of its community in a timely manner

Criterion 10.2.3

The MHS makes provision for consumers to access acute services 24 hours per day by either providing the service itself or information about how to access such care from a 24/7 public mental health service or alternate mental health service.

Assessor's Rating	Met

Criterion 10.2.4

The MHS, wherever possible, is located to provide ease of physical access with special attention being given to those people with physical disabilities and / or reliance on public transport.

Assessor's Rating	Met

STANDARD 10.3 Entry

The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Criterion 10.3.1

The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.

Assessor's Rating	Met

Criterion 10.3.2

The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.

Assessor's Rating	Met

Criterion 10.3.4

The entry process to the MHS is a defined pathway with service specific entry points that meet the needs of the consumer, their carer(s) and its community that are complementary to any existing generic health or welfare intake systems.

Assessor's Rating	Met

Criterion 10.3.5

Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.

Assessor's Rating	Met

Criterion 10.3.6

Where admission to an inpatient psychiatric service is required, the MHS makes every attempt to facilitate voluntary admission for the consumer and continue voluntary status for the duration of their stay.

Assessor's Rating	Met

Criterion 10.3.7

When the consumer requires involuntary admission to the MHS the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.

Assessor's Rating	Met

STANDARD 10.4 Assessment and review

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Criterion 10.4.6

The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons stated in criteria 10.4.5 above).

Assessor's Rating	Met

Criterion 10.4.7

The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment.

Assessor's Rating	Met

STANDARD 10.5 Treatment and support

The MHS provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Criterion 10.5.4

Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer.

Assessor's Rating	Met

Criterion 10.5.5

The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved.

Assessor's Rating	Met

Criterion 10.5.10

The MHS ensures that medication and / or other therapies when required, are only used as part of a documented continuum of treatment strategies.

Assessor's Rating	Met

Criterion 10.5.12

The MHS facilitates access to an appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.

Assessor's Rating	Met

Criterion 10.5.13

The MHS supports and / or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.

Assessor's Rating	Met

Criterion 10.5.14

The setting for the learning or the re-learning of self-care activities is the most familiar and / or the most appropriate for the skills acquired.

Assessor's Rating	Met

Criterion 10.5.16

The MHS endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

Assessor's Rating	Met

Criterion 10.5.17

The MHS promotes access to vocational support systems, education and employment programs.

Assessor's Rating	Met

STANDARD 10.6 Exit and re-entry

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criterion 10.6.1

The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.

Assessor's Rating	Met

Criterion 10.6.5

The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.

Assessor's Rating	Met

Criterion 10.6.6

The MHS ensures ease of access for consumers re-entering the MHS.

Assessor's Rating	Met

Criterion 10.6.7

Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

Assessor's Rating	Met

Criterion 10.6.8

The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

Assessor's Rating	Met

Org Name : Northern Beaches Hospital
Org Code : 126924

Rating Summary

STANDARD 1	
1.8	Met
1.9	Met
1.13	Met
1.15	Met
1.17	Met

STANDARD 2	
2.1	Met
2.5	Met

STANDARD 3	
3.4	Met
3.6	Met
3.7	Met

STANDARD 4	
4.4	Met
4.5	Met
4.6	Met

STANDARD 5	
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

STANDARD 7	
7.1	Met
7.3	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met
7.9	Met
7.11	Met
7.13	Met
7.14	Met
7.15	Met
7.17	Met

STANDARD 8	
8.1	Met
8.2	Met
8.5	Met
8.8	Met

STANDARD 9	
9.4	Met
9.5	Met

STANDARD 10	
STANDARD 10.1	
10.1.1	Met
10.1.3	Met
10.1.4	Met
10.1.5	Met
10.1.7	Met
10.1.9	Met
10.1.10	Met

STANDARD 10.2	
10.2.3	Met
10.2.4	Met

STANDARD 10.3	
10.3.1	Met
10.3.2	Met
10.3.4	Met
10.3.5	Met
10.3.6	Met
10.3.7	Met

STANDARD 10.4	
10.4.6	Met
10.4.7	Met

STANDARD 10.5	
10.5.4	Met
10.5.5	Met
10.5.10	Met
10.5.12	Met
10.5.13	Met
10.5.14	Met
10.5.16	Met
10.5.17	Met

STANDARD 10.6	
10.6.1	Met
10.6.5	Met
10.6.6	Met
10.6.7	Met
10.6.8	Met

Recommendations from Current Assessment

Standard 1

Organisation: All facilities under membership
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

Recommendation:
NBH develop an organisational IM&T strategic plan and road map for rolling out its digital systems and clinical and business intelligence platform.

Rating Summary

Northern Beaches Private Hospital

Health Service Facility ID: R100017

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 with Recommendation
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
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

Action	Assessment Team Rating
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

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

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met

Action	Assessment Team Rating
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

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

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Northern Beaches Public Hospital

Health Service Facility ID: R100017

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 with Recommendation
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
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

Documentation of patient information

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

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

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

Delivering comprehensive care

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

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

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

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Nil