NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

The Sydney Clinic

Sydney, NSW

Organisation Code: 120616
Health Service Facility ID: 101028
Assessment Date: 11/02/2020 to 12/02/2020

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

The Sydney Clinic underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 11/02/2020 to 12/02/2020. The NS2 OWA required two assessors for a period of two days.

The Sydney Clinic is a Private health service. The Sydney Clinic was last assessed between 01/03/2017 and 02/03/2017. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
The Sydney Clinic	101028

General Discussion

The Sydney Clinic (TSC) is a private 44-bed mental health hospital and is part of the Healthscope (HSP) a national private healthcare provider with 43 private hospitals in Australia. It is situated in the eastern suburbs of Sydney and provides a varied range of treatments for mood-related disorders, substance abuse and behavioural therapies for patients. TSC programs are conducted by a multidisciplinary team and any patient who is experiencing acute symptoms may be admitted for a period of time. TSC inpatients are admitted to either the Mood Disorder Unit-level 1 or the Alcohol and Other Drugs Unit-level 2.

TSC is monitored for performance by HSP Key Performance Indicators (KPIs) and the HSP reporting requirements for the Mental Health, Work Health & Safety and Infection Prevention & Control (IP&C) hospital clusters. Data which measures the safety and quality of its services is published to demonstrate that TSC is maintaining and improving its standards of patient care.

Country of birth admissions are monitored with Ireland identified as the highest in 2019 but the total patient population reflects that most admissions 86% were born in Australia and the ages being within the 35 to 44 years age group.

TSC continues to maintain numerous partnerships including the Sydney University, Notre Dame University, the University of New South Wales (NSW), Jewish House (Rabbi Mendel Kastel is an appointed Mental Health Commissioner) and many community groups and services.

HSP has engaged KPMG to gain a comprehensive view of all HSP existing mental health services including key challenges and future opportunities with a particular focus on the patient pathway from referral to discharge. TSC was to participate in a site workshop with KPMG following their ACHS assessment. TSC has a documented exclusion criterion which includes age, serious physical illness and involuntary legal status. There is a suite of policies to guide the admission, assessment and care planning processes which includes identification, prevention and management of pressure injuries, falls, nutritional deficits, cognitive impairments including delirium, self-harm and aggression.

Processes for structured clinical handover are used to effectively communicate about the health care of patients and includes the bedside handover and patient care boards that were evident in each patient bedroom.

Staff focus on supporting the development of individual goals for recovery and support the development of skills that enable a patient to achieve those goals. Care plans were developed in collaboration with the patient as evidenced by the patient signature on the care plan. However, the involvement of nominated family/carers in the care planning process needs to be strengthened.

A range of standard measures is used to understand the change in the patient's presentation during inpatient admissions and participation in the group programs.

There is an established infection control framework to prevent and control the spread of infection that is supported by policies and education. Cleaning schedules are in use and reviewed with appropriate action items. Infection control is part of the mandatory training for staff.

TSC has in place systems to ensure appropriate governance in relation to medication management and safety. Comprehensive medication history including any allergies forms part of the admission and discharge process and Medication Management Plans were evident in the medical records viewed by the assessors.

Medication incidents are reported via the RiskMan system and reviewed by the appropriate committee and regular medication chart audits are undertaken by the pharmacist.

There is an antimicrobial Stewardship System in place underpinned by policy and procedures and managed via the Quality and Safety and IPC committees.

Summary of Results

The Sydney Clinic achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

The Sydney Clinic achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

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

The Sydney Clinic

Sites for Assessment

Sites for Assessment - The Sydney Clinic

The Sydney Clinic HSF ID:101028		
Address: 22-24 Murray Street BRONTE NSW	2024	Visited: Yes

The Sydney Clinic

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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

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

Not Applicable	

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

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

Assessment Team Summary:

The Sydney Clinic (TSC) operates within the overarching policies and strategic direction of Healthscope who report performance publicly against quality and clinical outcome metrics.

TSC adheres to the STAR values of:

- Service Excellence
- Teamwork and Integrity
- Aspiration
- Responsibility.

TSC who actively support the transparent public reporting of healthcare quality data actively participates in the Australian Commission on Safety and Quality in Healthcare (ACSQHC) and the Australian Institute of Health and Welfare (AIHW) with Healthscope having representation on the MYHospitals Advisory Committee.

All TSC departments are encouraged on an ongoing basis to manage and contribute to all safety and quality activities within TSC.

An Integrated Risk Register is in place and all incidents are reported via RiskMan with reports tabled at the Medical Advisory Committee (MAC), Heads of Department (HODS) plus Quality and Safety and Work Health and Safety Committees.

TSC has implemented strategies to meet the needs of the Aboriginal and Torres Strait Islander (ATSI) patients although the percentage of admitted ATSI patients to date is minimal.

All clinicians are supported to perform their delegated safety and quality roles to operate within the TSC clinical governance framework, contribute to business decision making and to continually improve the safety and quality of TSC patient's health care.

Patient safety and quality systems

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

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

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

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

Not Applicable	

Assessment Team Summary:

TSC operates its services with a strong focus on risk management at all levels. All overarching HSP policies which guide TSC are subject to three-yearly review unless required more frequently ensuring that the effectiveness and currency of its policies, procedures and protocols are closely monitored.

Comprehensive and frequent risk reporting to the relevant TSC committees contributes to both risk identification and risk reduction with the collection and contributing of clinical data identifying risk levels also aims in the reduction and elimination of clinical and operational risk. Analysis of risks and the reporting of incidents continues to contribute to the ongoing safety and quality of the organisation.

An Open Disclosure process is activated when required and is consistent with the Australian Open Disclosure framework.

Processes are in place to obtain feedback from patients via patient survey, the complaints system and the weekly Patient Forum. This forum is providing immediate feedback from the inpatient population at a point in time.

The hard copies of TSC patient healthcare records are available to clinicians at the point of care and comply with security and privacy regulations.

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:

The orientation program at TSC is sound and processes are in place to monitor the ongoing designated roles and responsibilities of all staff. There had been recent changes to a number of senior clinical positions with two TSC clinicians currently occupying the acting positions of Director of Nursing and Quality Manager. An Indigenous Psychologist model has been introduced to improve cultural awareness and cultural competency across TSC with the social worker model also being adjusted to meet patient needs.

The TSC mandatory training/education program was sighted by the assessors and meets all the HSP benchmarks for mandatory training.

The credentialing system is monitored by HSP and supervision of clinicians is available as required or as set by a clinician's award.

All clinicians are subject to performance review and are required to participate in a clinical review of their practice.

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:

TSC operates successfully on a compact site with minimal outdoor space or room for expansion.

The design of TSC demonstrated to assessors that patient rooms whilst small continue to operate at an optimal level with both staff and patients finding TSC fit for purpose.

The signage is clear the environment appears safe and was identified as a calm and quiet environment conducive to the care of both mental health and AOD patients at the time of assessment.

Patients are not admitted overnight to TSC. In conjunction with the Indigenous Psychologist TSC have introduced a welcoming environment beginning at the point of entry for ATSI patients in recognition of their cultural beliefs and practices.

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:

TSC demonstrated that the quality and safety systems in place are aligned to the partnering with consumer policies and procedures. TSC demonstrated they include patients and families/carers as partners in their own care and can as voluntary patients choose the extent of involvement.

Since the previous ACHS assessment, TSC has participated in the strategic vision for 2021 of the Central and Eastern Sydney Primary Health Network to improve health and the wellbeing of consumers in the region in transforming their care.

TSC has adopted a Consumer Consultants Model and employed four consultants each with a defined role.

1. Revision of services, internal systems, patient needs and promotion of co-design initiatives.
2. Consumer support in marketing and advertising with a focus on a change to the use of recovery language and improving current in-patient information.
3. The evaluated "Next Steps Peer Support Program", and
4. The role of the ECT Peer Volunteer.

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:

TSC uses the current Australian Charter of Healthcare Rights which is accessible to patients' carers and families.

Consent and the requirement of consent for treatment, ECT and financial were evidenced and comply with legislation, best practice and monitored accordingly.

At times a patient may not initially have the capacity to make decisions about their own care and needs but this is acknowledged and well supported by the patient's Consultant Psychiatrist and clinicians at TSC.

When a patient can or is well enough, they are considered a partner in making decisions about their current and future care. Assessors evidenced that clinicians and all staff are partnering with their patients and are actively including them in decisions about their own care.

All TSC patients post-discharge are sent a discharge-based survey which is anonymous and voluntary. The HSP mental health committee is reviewing the 46 questions set by HSP as to their applicability to their mental health sites.

Suggestions for Improvement:

The HSP policy reference No 2.50 states post-discharge follow-up telephone calls are made to BUPA patients that meet certain criteria.

It is suggested that all TSC patients receive a telephone call within seven days of discharge (if they have consented to receive telephone contact) as an essential step in good communication practice post-discharge.

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:

Clear evidence was available that demonstrated TSC had maintained and was improving good communication to support their focus on the continuing effective partnership model.

Assessors noted the work being undertaken by the Consumer Consultant in the change of language in information to a recovery focus style and the improvement in in-patient information and the work that has and is being undertaken in the development of the TSC Guide to Mental Health Information and Services.

Suggestions for Improvement:

TSC are encouraged to progress the completion of TSC Carers Guide to Mental Health Information and Services and include a focus on the involvement of the families/carers or support person.

Ensure the current electronic version of the Patient Information Directory is available in hard copy if requested by a patient or family member.

Partnering with consumers in organisational design and governance

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

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

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

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

Assessment Team Summary:

The General Manager demonstrates a commitment to involve consumers/patients in continuing discussions around design, measurement and evaluation of the healthcare provided by TSC.

Support is provided to the Consumer Consultants and training is provided as required.

While the ATSI patient group is minimal at TSC the employment of the Indigenous Psychologist and the creation of an environment that recognises ATSI customs and cultural beliefs it is also important for all patients and staff to gaining an understanding of mental health impacts for this diverse group of consumers.

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:

TSC retains the long-standing consultative services of HICMR which is responsible for the control and distribution of service policies relating to Infection Prevention and Control (IP&C) to ensure that they are in line with relevant Australian and International guidelines.

The HICMR policies for IP&C are accessible to all staff via a desktop link with the login and password located on each computer with the processes in place to inform staff of any new or updated policies.

A range of quality measures identifies that TSC has an established infection control program that is supported by the appropriate expertise, policies and education with staff trained and were observed at assessment in the use of standard precautions.

Infection incidents are entered into RiskMan and reported to the Quality and Safety Committee for recommendations and appropriate actions. Maintenance and cleaning schedules are in place and auditing is undertaken.

All newly appointed staff must provide evidence of their immunisation status before they commence employment and TSC runs an active annual immunisation program for all staff with compliance rates continuing to improve each year.

Although the risk and incidence of healthcare-acquired infections is very low there are clear efforts taken to mitigate the risk of clients acquiring an infection.

Clean and soiled linen was appropriately stored in all areas visited by the assessors and there are no patient laundry facilities onsite.

During assessment, the Coronavirus outbreak was a global concern. Healthscope had provided information and factsheets for TSC staff and patients on symptoms and steps to contain the spread and risk of contagion. It was observed by assessors during the intake process that patients were asked directly about their recent travel and possible contact with persons who had a proven case of the coronavirus with the information documented.

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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:

All areas of TSC visited by the assessors were clean, organised and free from clutter. Regular environmental audits were evident and staff obviously took pride in their workplace.

Infection control is part of the mandatory training for staff which includes a training package on aseptic technique (AST). All mandatory training including AST is captured on the training database with results above the 85% benchmark.

TSC is fortunate to have three gold standard trained auditors.

Hand hygiene stations and signage were available throughout the clinic and information displayed requesting friends/families to not visit patients at TSC if they are unwell.

Personal Protective Equipment (PPE) was available for staff along with appropriate training to support its use. Sharp containers and waste management strategies were appropriately placed and evident.

A comprehensive physical assessment is conducted on all patients within 24 hours of admission by the General Practitioner which includes infection control screening and if further tests are required to clarify the health status of the patient this is referred off-site for further investigations. Routine clinical observations are conducted daily and any patients who become medically compromised are reviewed by the GP and transferred to more appropriate hospital care.

On transfer or discharge, the patient's infectious status is documented and communicated to the receiving service provider.

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

There is no sterilising or reprocessing of medical equipment, instruments or devices at TSC. The only non-invasive reusable devices used are blood pressure cuffs; these are cleaned following each use and this is monitored.

Antimicrobial stewardship

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

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

Assessment Team Summary:

Antimicrobial Stewardship appears well-managed by supporting policies and therapeutic guidelines.

Antibiotic prescribing is monitored by the pharmacist during medication chart reviews. AMS is incorporated in Pharmacy meetings; infection rates are reviewed, monitored and presented at Medical Advisory Committee meetings. Information sheets are given to patients who are prescribed antibiotics.

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:

There is an extensive suite of policies, procedures, guidelines and protocols available to support safe medication management. Medication management education is part of the nursing education program and medication incidents are recorded, reviewed, and organisation monitoring is ongoing.

On admission to TSC, a comprehensive medication history is documented including allergic reaction to any medication. Any allergies and alerts are recorded in the patient's medical record and an alert sticker placed in the medical record and on the medication chart. There is regular auditing of the medication charts by the HPS pharmacist.

At discharge, patients are provided with a reconciled medication list completed by the pharmacist which includes an explanation of any medication changes or cessations. Information regarding medication is also provided on the medical discharge summary to ensure continuity of care.

There is a seven-day delivery service to TSC for any prescribed medications not currently stocked and clinical staff have access to the 24hour telephone HPS on-call pharmacy service available to respond to any question/s regarding patient/s medication.

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:

On admission to TSC, a comprehensive medication history is documented including allergic reaction to any medication. Any allergies and alerts are recorded in the patient's medical record and an alert sticker placed in the medical record and on the medication chart. There is regular auditing of the medication charts by the pharmacist.

All patients admitted to TSC have identification photos on the front of their medical record and medication chart. A review of medical records by the assessors found large-good quality photos of patients, including consent for this form of identification. The patient identification and procedure matching systems include the use of the three nationally approved identifiers for inpatients and outpatients. A white identity wrist band listing the three patient identifiers is worn by the patient unless the patient has an alert when the band is red. Patient identification and procedure matching are well understood and given appropriate attention by all staff.

There are good practices in place to guide storage and return of patients' own medications, instructions regarding new medications, and disposal where indicated. The medication management plan is completed on admission and used to obtain the best possible medication history of patients admitted to TSC.

Medications are discussed with the patient during bedside handover and medication charts reviewed at the clinical handover.

Although very few patients are on Clozapine, TSC has a dedicated Clozapine coordinator.

There were signs on both floors advising of medication times and the need for patients to wear their ID armbands. Schedules 8 and 4 restricted medications were appropriately stored, and the registers maintained.

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:

TSC has the support of the HSP who attends the clinic four times a week. The pharmacist also conducts medication policy reviews and supports both staff and patients in the monitoring of medication management. The MMP provides a medication history on admission to TSC and is monitored throughout the patients stay and this is supported by the Patient Health History designed to ensure all current and past medications are documented on admission.

During the patients stay medications are reviewed during clinical review and daily clinical handover.

Patients are provided with comprehensive information regarding their prescribed medication including any possible side effects and the reasons for any changes to their medication during their stay and on discharge.

A medication group is held weekly, and nursing and medical staff are available to discuss issues or concerns both with the patient and their family/carer regarding medication management.

Comprehensive information on the prescribed medication for each patient is provided to the treating GPs/Psychiatrists (with consent) on the patients' medical discharge summary.

Medication management processes

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

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

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

Assessment Team Summary:

There are comprehensive policies and protocols in place that drive continuous safety and quality of care of this standard. There is evidence that medication incidents are well documented and trended via RiskMan and are reported to the appropriate committees.

Both first floor and second floor had clean and secure medication rooms with clear workbenches.

Schedule 8 and schedule 4 restricted medications were appropriately stored and the registers well maintained.

The assessors noted that the temperature of medication fridges at TSC were monitored daily with all out-of-date medication stock identified by the pharmacist who also collected unwanted controlled medications.

The medication error reflection form is completed following any medication incidents and is actioned as a non-punitive tool designed to help staff identify strategies that may avoid similar errors in the future.

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:

At the initial triage and admission, appropriateness procedures are clear and include assessment of a patient's physical and mental health. The patient's medical condition and mobility are reviewed and their suitability for the environment and surrounds is determined.

There is a suite of policies available to guide staff in the delivery of effective clinical communication. During orientation, staff receive training in the ISOBAR (identify–situation–observations–background–agreed plan–read back) tool to support clinical handover. The culture at TSC is about the involvement of the patient in their own care with a strong focus on patient-centred care and program participation for both inpatients and outpatients.

Patients who are admitted and identified at risk have the risk and management strategies documented on the care plan. Where appropriate and necessary behavioural management plans are implemented.

Clinical audit results and incidents are reported at the Quality and safety and Medical Advisory Committee meetings for review. Clinical risks identified are added to the risk register and evaluated and mitigated.

During admission patients have routine observations recorded daily and the GP is available to review any patients if they become medically unstable. REACH posters advise family/carers to contact staff if they are concerned about patients or their care.

ATSI cultural sensitivity guidelines are available with staff having access to cross-cultural awareness training. The admission documentation includes the opportunity to identify consumers of ATSI status.

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:

TSC utilises a standardised suite of comprehensive clinical assessment forms that determine ongoing treatment and care planning ensuring a patient's needs are understood and considered. Assessments and care plans are completed with the patient, and when relevant their family/carer. Care plans were evident in the medical records reviewed by the assessors, but it was difficult to ascertain if carers/family had been involved as their signatures were not always evident on the care plan. The low compliance rate was supported by the clinical documentation audits. The assessors suggest a more robust system be implemented to ensure, where appropriate, family/carers are included in the care planning process and care plans are signed by both the patient and their nominated family member or carer.

All patients admitted are routinely screened for falls and pressure areas and additional risk assessments are conducted if a patient's health status changes.

Patients and their carers are provided with information on the process of escalating care if they have any concerns. This includes orientation to an emergency button placed in each patient's room.

There was evidence in the medical records viewed by the assessors that patients have routine observations taken to monitor their physical health and risk assessments were regularly reviewed and updated.

It was pleasing for assessors to note the use of outcome measures forming part of routine clinical practice. There is a low CALD population admitted to TSC, but specific cultural and ethnic groups are supported if required.

Suggestions for Improvement:

It is suggested that a more robust system be implemented to ensure carers/family members are involved in patient care and the patient care plan is signed by the family/carer to demonstrate this. If the patient does not consent or the family member or carer refuses to sign this must be documented and form a component of the documentation audit.

Delivering comprehensive care

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

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

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

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

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

Not Met	
Not Applicable	

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

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

Assessment Team Summary:

The daily bedside handover observed by the assessors demonstrated a systematic approach to the handing over of patient-related information from the day to afternoon shift with the patient and their family/carers if they were present.

The bedside handover is an important part of ensuring continuity of care that supports continuing assessment and planning for discharge. Patients were also able to have their immediate needs identified and a staff member was allocated the responsibility for completion of the activity within an agreed timeframe. Patients described to the assessors a high level of satisfaction with being included in the handover process. Although most patients are ambulant, having the clinical handover in their bed area helped ensure a degree of confidentiality.

On admission, the Patient Health History completed by the patient asks if they have an Advance Care Directive (ACD).

Any deterioration is recognised through daily recording of physical observations, mental health review and consultation with the treating team and family/carers.

If patients become medically compromised, they are reviewed and transferred to a more suitable health care facility including transfer to appropriate care for end-of-life care directives.

Minimising patient harm

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

Not Applicable	

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

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

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

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

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

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

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

Assessment Team Summary:

Patients of TSC are treated in the least restrictive environment. All patients are voluntary. Policies are in place in the event that the patient's voluntary status changes and they are transferred to a public mental health unit.

There are a comprehensive assessment and intake process. This assessment includes a comprehensive biopsychosocial assessment, along with the assessment of risk across a variety of domains including, self-harm and aggression.

TSC does not seclude or restrain patients. Policies are in place to ensure that consumers who are a danger to themselves or others receive appropriate care in a more appropriate facility.

Staff delivering the programs at TSC have a clear commitment to engagement, explanation of the components of the program and the importance of relapse prevention.

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:

TSC has systems in place good communication channels to ensure the continued delivery of safe care the TSC inpatient and outpatient population. The application of the principles of the Clinical governance standard has overarching oversight from HSP and the ongoing shared learnings from the HSP Mental Health Committee.

The continuous communication with patients was evidenced in patient forums, bedside handovers and within the group programs. patient identification processes appeared sound, the transfer of a patient to and from TSC are governed by policy and sound process and there is ongoing communication between the Consultant Psychiatrists and Registrar.

Risk levels of all patients is a component of care and the information is transferred between the multidisciplinary team's clinicians and at discharge.

TSC has now introduced the auditing of clinical handover as part of the consultation process between consumers and carers.

Suggestions for Improvement:

TSC to continue clinical bedside handover auditing to ensure that discharge planning is part of the discussion with all inpatients if appropriate and their carer if present.

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:

TSC is using three approved identifiers evidenced in medical records and at handover. TSC uses both photographic and armband identification of patients as required.

The process of matching a patient to their care was evidenced at medication administration and in the Electro Convulsive Therapy (ECT) suite at handover and time-out.

Armbands were sighted on TSC patients by assessors during handover, the use of the three identifiers at medication administration and during observation of ECT with these checks including both the patient and clinician/s.

Communication at clinical handover

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

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

Assessment Team Summary:

The two bedside handovers assessors participated in evidenced a well-structured clinical handover process with the relevant clinical information shared between the morning and afternoon staff on the two patient floors at TSC.

The inpatients were encouraged to participate in the bedside handover with the scheduled time allowing the patients to be in their rooms at the designated time.

Carers and families are encouraged to participate and the handovers observed demonstrated a focus on the importance and quality of the transfer of care and responsibility between clinicians.

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:

TSC is aware of the importance of the communication of critical information for the patient and care.

Patient risk is subject to constant monitoring and any change is communicated to the treating Consultant Psychiatrist, Registrar and all clinicians involved in the care of a patient.

A patient who has had their risk level/rating increased or an alert introduced is part of the role of a mental health clinician and any risk level increase or decrease is communicated and documented in the clinical notes.

Families and carers are encouraged to communicate critical information of any identified or suspected risk that may impact on the care and treatment of the patient whilst a patient of TSC, prior to potential discharge or post-discharge.

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:

TSC mental health clinicians maintain a strong focus on the importance of the documentation of critical information alerts and any changes in a patient's risk level on a shift by shift basis or more frequently if required.

Any reassessment of a patient's ongoing treatment or changes to the patient care plan is documented and communicated to the treating clinicians.

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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

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

Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

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	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

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:

TSC has policies and procedures in place for the recognition and response of the deteriorating patient.

The TSC strategic plan includes recognition and response to the deteriorating patient in accordance with the HSP Safety and Quality Plan (Clinical Governance Framework).

TSC submits quarterly data to HSP on patient acute deterioration as a quality key performance indicator (KPI).

All MET calls and Code Blue events are entered into RiskMan with TSC achieving 100% compliance against an HSP benchmark of 92%.

TSC has access to the six HSP Recognising and Responding to Acute Deterioration HSP policies these include:

- Patient Risk and Observation levels
- Delirium and Cognitive Impairment Prevention and Management
- Recognising and Responding to Clinical Deterioration.

Patient information includes Cardio Pulmonary Resuscitation (CPR) as an informative and educative inclusion.

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:

TSC clinicians have access to the six-key related HSP policies. On admission, all patients have a baseline mental health risk assessment and physical observations taken with the TSC General Practitioner (GP) completing a physical examination within the first 24hours of admission. The admitting clinician completes a mental health risk assessment and physical observations which are documented on the revised mental health forms the standard observation forms and clinical charts to assist clinicians in the continuing evaluation and recognition of any deterioration in a patient's mental health state.

The outcomes of the assessments and observations determine the frequency of observations for each patient.

Mental and physical health observations are clearly defined with the mental health visual observations including:

- Patient sighting
- Checking the location and activity of patients
- Assessing for any change in behaviour presentation or condition
- Checking the environment for safety.

Patients are checked for delirium risk factors by the use of the Cognitive Impairment Risk Assessment Tool (CIRAT) with any deterioration in a patient's mental state escalated to the TCS registrar and the patient's consultant psychiatrist.

There are processes in place to manage the deterioration of a patient's mental health state by comparing it to the most recent and/or baseline information obtained at admission which may indicate a transfer out to a tertiary facility for additional care adhering to the HSP Inter-hospital transfer of a patient.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

Mental state deterioration is assessing change based on the individual baseline information to which a current mental state can be compared. The key indicators are-

- Reported change
- Distress
- Loss of touch with reality or consequence of behaviours
- Loss of function

- Elevated risk to self, others or property

The Risk management and observation levels in the TSC inpatient units are graded as high, moderate or low.

There are many points during a patient's admission journey at TSC including the mental state examination, risk assessment and management of risk.

If there is a significant change in a patient's clinical condition then the primary nurse, the Registrar and the Consultant Psychiatrist (VMO) are notified for ongoing management, recommendation or the decision to transfer out to a tertiary facility.

Recommendations from Current Assessment

Nil

Rating Summary

The Sydney Clinic

Health Service Facility ID: 101028

Standard 1 - Clinical Governance

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

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

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Not Applicable
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Not Applicable

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	Not Applicable

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
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	Not Applicable
7.2	Not Applicable
7.3	Not Applicable

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Not Applicable
7.5	Not Applicable
7.6	Not Applicable
7.7	Not Applicable
7.8	Not Applicable

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Not Applicable
7.10	Not Applicable

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