NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Brisbane Private Hospital

BRISBANE, QLD

Organisation Code: 720561
Health Service Facility ID: 101148
Assessment Date: 02-05 February 2021

Accreditation Cycle: 1

Disclaimer: The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the ongoing safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.
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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

Brisbane Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 02/02/2021 to 05/02/2021. The NS2 OWA required three assessors for a period of four days. Brisbane Private Hospital is a Private health service. Brisbane Private Hospital was last assessed between 11 September 2017 and 14 September 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
Brisbane Private Hospital	101148

General Discussion

The Brisbane Private Hospital (BPH) is a part of the broader Healthscope group of hospitals and has undergone significant governance changes as a result of a recent ownership change. This together with the COVID-19 outbreak in 2020 has resulted in a disruption to operations and has delayed some of the actions planned during this period. In spite of these issues, BPH has continued to provide services where allowed by Queensland Health Directives and the results during this period have been reported and performance maintained.

Governance systems are provided corporately by Healthscope and implemented locally by BPH. Overall, these systems are mature and provide a solid basis for BPH to continuously improve. In saying this, there have been some challenges during COVID-19 in maintaining various Committees and their attendance, thus reporting and monitoring against their Terms of Reference. It was evident that the systems and process around Clinical Governance across the organisation have been impacted by COVID-19 with a number of meetings cancelled, yet to be reinstated and also planned works being deferred which has created some confusion for staff.

The hospital provides an array of elective surgery and procedures with 15 operating theatres and two procedural rooms. In addition, BPH provides a significant alcohol and drug treatment service with both inpatient and outpatient services in a designated unit called Damascus. There is no emergency department and most patients are seen in the doctor’s private rooms prior to admission.

There have been some issues identified in relation to workplace health and safety in Endoscopy Suite as well as the planning and implementation of strategies for Aboriginal and Torres Strait Islander consumers. These will be discussed in detail in the report.

BPH’s consumer engagement plans cascade well from the Healthscope strategic documents, however, a number of these are out of date and up for review and replacement. This creates a unique opportunity for BPH to liaise with Healthscope to ensure that both BPH’s plans as well as the strategic guiding documents are fully compliant with the specific actions and intentions of the Second Edition of the National Safety and Quality Health Service Standards as well as the related advisories.

The consumer engagement viewed in the Damascus Unit is active and improving. BPH as part of the evaluation of current engagement systems may wish to highlight the achievements of this unit as a model for the remainder of the facility.

This assessment under the mandatory National Safety and Quality Health Service (NSQHS) Standards has resulted in the hospital receiving eight Met with Recommendation action ratings in five of the Standards, and four Not Met Actions in three of the Standards. The overall recommendations included five in the Clinical Governance Standard; two in Partnering with Consumers; two in Infection Prevention and Control; two in the Comprehensive Care; and one in Communicating for Safety. In line with Australian Commission on Safety and Quality in Health Care (ACSQHC) requirements, the actions rated Not Met and Met with Recommendation will be reviewed at final assessment.

The assessors found that staff genuinely work to provide high standards of care to their patients/ clients and are strongly committed to the organisation.

Summary of Results

At Brisbane Private Hospital's Organisation-Wide Assessment four Actions were rated Not Met and 8 Actions were rated Met with Recommendation across 8 Standards.

The following table identifies the Actions that were rated Not Met and Met With Recommendation and lists the facilities to which the rating applies.

Actions Rated Not Met	Action Required	Name of Health Service Facilities where action was deemed to be Not Met
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	All Facilities under membership
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	All Facilities under membership
2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	All Facilities under membership
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	All Facilities under membership

Actions Rated Met With Recommendation	Action Required	Name of Health Service Facilities where action was deemed to be Met With Recommendation
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	All Facilities under membership
1.31	The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	All Facilities under membership
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	All Facilities under membership

Actions Rated Met With Recommendation	Action Required	Name of Health Service Facilities where action was deemed to be Met With Recommendation
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	All Facilities under membership
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	All Facilities under membership
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	All Facilities under membership
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	All Facilities under membership
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	All Facilities under membership

Final Assessment Requirement

As there are actions rated Not Met and Met with Recommendation, there is a requirement of the Australian Commission on Safety and Quality in Health Care (ACSQHC) that the health service organisation is given a period of remediation and the Not Met and Met with Recommendation actions undergo a final assessment within 60 business days of the initial assessment.

Summary of Recommendations Subject to the Final Assessment

Action	Health Service Facility	Recommendation
1.4	All Facilities under membership	Undertake a detailed review of the data available to Brisbane Private Hospital and Healthscope in order to: 1. Identify any specific health service needs, gaps or clinical risks specific to Aboriginal and Torres Strait Islander consumers of BPH. 2. Develop, implement and monitor a plan with strategies to address any specific Aboriginal and Torres Strait Islander health service needs identified.
1.29	All Facilities under membership	Refer to Recommendation in 3.12 As a matter of priority; a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to: 1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards. 2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed. 3. Increase staff and patient safety through the provision of a safer environment. 4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.
2.13	All Facilities under membership	Consult with local Aboriginal and Torres Strait Islander communities to develop

Action	Health Service Facility	Recommendation
		and implement the plan outlined at Action 1.4.
3.12	All Facilities under membership	As a matter of priority, a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to: 1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards. 2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed. 3. Increase staff and patient safety through the provision of a safer environment. 4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.

The recommendations associated with the above ratings are included below. These recommendations need to be addressed by the health service before the next onsite assessment.

Action	Health Service Facility	Recommendation
1.2	All Facilities under membership	BPH seek direction from the Governing Body in relation to Aboriginal and Torres Strait Islander health priorities and confirm that those measures that are developed following the expiration of the Healthscope Reconciliation Action Plan May 2019 - May 2020 fully comply with the intent of the six Aboriginal and Torres Strait Islander actions in the National Safety and Quality Health Service Standards.
1.31	All Facilities under membership	In liaison with consumers, review the wayfinding signage and directions for Brisbane Private Hospital to ensure that they are clear and fit for purpose.
1.33	All Facilities under membership	Continue to work with local Aboriginal and Torres Strait Islander communities to

Action	Health Service Facility	Recommendation
		identify and develop a welcoming environment for Aboriginal and Torres Strait Islander peoples.
2.11	All Facilities under membership	Brisbane Private Hospital evaluate the expired BPH Consumer Engagement Plan and develop, implement and monitor a replacement which includes how the organisation will sustain the Consumer Consultant Program.
3.14	All Facilities under membership	As a requirement of the Advisory 18/07 Version 6.0, 1. a Gap analysis be completed for Endoscopy by June 2021, 2. an implementation plan be developed, documented and endorsed by Executive by December 2021, 3. the plan be progressed to be completed by December 2023 according to the Advisory 18/07.
5.4	All Facilities under membership	The templates for undertaking Comprehensive Care plans in the Damascus Unit be developed and endorsed in a timely manner to provide purposeful, individualised patient care that is targeted at the primary diagnosis.
5.24	All Facilities under membership	A comparative review be undertaken of current practice for the management of falls at Brisbane Private Hospital against the best practice guidelines provided by the Safety Commission: Preventing Falls and Harm from Falling. Particular attention should be focused on flagging alerts.
6.6	All Facilities under membership	1. The language in the policy and audit tools used for 'timeout' be aligned with clear definitions and education be provided to facilitate compliance. 2. The 'timeout' process in all theatres and procedure room fully comply with the intent of the policy which is measured by a revised audit tool.

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

Brisbane Private Hospital

Sites for Assessment

Sites for Assessment - Brisbane Private Hospital

Brisbane Private Hospital HSF ID:101148	
Address: 259 Wickham Terrace SPRING HILL QLD 4000	Visited: Yes

Brisbane Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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:

Brisbane Private Hospital (BPH) has undergone significant governance changes as a result of an ownership change in 2019. This together with the COVID-19 outbreak in 2020 has resulted in a disruption to operations and has delayed some of the actions planned during this period. In spite of these issues, BPH has continued to provide services where allowed by Queensland Health Directives and the results during this period have been reported and performance maintained.

The parent Healthscope Board have outlined four governance pillars, and these are used by BPH to focus activity, monitoring and reporting. They are: Quality Clinical Outcomes, Exceptional Patient Care, Creating Extraordinary Teams, and Market Leading Returns.

The organisational structure for BPH reflects the service profile of the organisation and the committee structure reflects strong clinician involvement in clinical governance systems. Consumer participation has been interrupted in recent times and the organisation is encouraged to re-develop the roles for consumer consultants in key clinical governance committees. This will be expanded upon under Standard 2.

The plans for BPH cascade from the Healthscope Strategic Plan and Clinical Governance Safety and Quality Plan. BPH plans reflect the Healthscope 'STAR' values of service excellence, teamwork, aspiration, and responsibility.

BPH has a complex system of KPIs which are monitored and assessed against targets and they include Healthscope, ACHS, and other indicators. Variance from expected targets is flagged and acted upon with internal and external reporting required to outline how the variance will be managed. Any compliance risks are listed on the risk register.

Incidents are managed according to the incident and risk management policies and systems, and this will be discussed later in more detail under those actions.

In relation to strategic guidance for Aboriginal and Torres Strait Islander health priorities, BPH relies on the Healthscope Reconciliation Action Plan May 2019 - May 2020. This document has expired and does not outline specific Aboriginal and Torres Strait Islander health priorities. It does not meet the intention of the NSQHSS Edition 2, Action 1.2. A recommendation has been made in this report for BPH to seek direction from the Governing Body in relation to Aboriginal and Torres Strait Islander health priorities and whether those that are developed following the expiration of the Healthscope Reconciliation Action Plan May 2019 - May 2020 fully comply with the intention of the six Aboriginal and Torres Strait Islander actions in the National Safety and Quality Health Service (NSQHS) Standards.

Senior clinical leadership in the clinical governance systems is well entrenched at BPH and the Mortality and Morbidity and craft groups reporting to the Medical Advisory Committee (whose function is outlined in the organisation's by-laws) ensure that clinicians are enabled to review and recommend action when indicated.

Action 1.4 requires an analysis of health service and outcomes gaps for Aboriginal and Torres Strait consumers and community to determine any specific health service needs which are then used to implement and monitor any specific Safety and Quality (S&Q) priorities for those consumers. The organisation does not have plans which outline specific health service strategies to meet the specific safety and quality priorities for Aboriginal and Torres Strait peoples.

As a result, Action 1.4 has been assessed as Not Met and a recommendation made for BPH to undertake a detailed review of the data available to the organisation and Healthscope in order to:

1. Identify any specific health service needs, gaps or clinical risks specific to Aboriginal and Torres Strait Islander consumers of BPH.
2. Develop, implement and monitor a plan with strategies to address any specific Aboriginal and Torres Strait Islander health service needs identified.

It is noted that the Attestation Statement provided by the organisation prior to assessment includes BPH as fully complaint with the actions in relation to Aboriginal and Torres Strait Islander peoples. Even though BPH has a low proportion of Aboriginal and Torres Strait Islander consumers, this does not negate the requirements for compliance with this and other Aboriginal and Torres Strait related actions. The Australian Commission for Safety and Quality in Health Care Advisory 18/04 outlines the process for applying for 'not applicable' status for Actions 1.2, 1.4, 1.33, and 2.13. BPH has not undertaken this process and the inclusion of all Healthscope facilities in the Attestation Statement currently precludes this for any individual facility.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: In relation to strategic guidance for Aboriginal and Torres Strait Islander (ATSI) health priorities, Brisbane Private Hospital relies on the Healthscope Reconciliation Action Plan May 2019 - May 2020. This document has expired and does not outline specific ATSI health priorities. Despite this the document is still used as the basis for strategies at a local level to engage with Aboriginal and Torres Strait Islander people. Expected.
Recommendation:
BPH seek direction from the Governing Body in relation to Aboriginal and Torres Strait Islander health priorities and confirm that those measures that are developed following the expiration of the Healthscope Reconciliation Action Plan May 2019 - May 2020 fully comply with the intent of the six Aboriginal and Torres Strait Islander actions in the National Safety and Quality Health Service Standards.
Risk Rating:
Low
Risk Comment:
The proportion of Aboriginal and Torres Strait Islander consumers in the service is low and the likelihood of adverse outcomes low.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Not Met
Assessor Comment: Action 1.4 requires an analysis of health service and outcomes gaps for ATSI consumers and community to determine any specific health service needs which are then used to implement and monitor any specific safety and quality (S&Q) priorities for those consumers. The organisation does not have plans which outline specific health service strategies to meet the specific safety and quality priorities for ATSI peoples.
Recommendation:
Undertake a detailed review of the data available to Brisbane Private Hospital and Healthscope in order to: 1. Identify any specific health service needs, gaps or clinical risks specific to Aboriginal and Torres Strait Islander consumers of BPH.

2. Develop, implement and monitor a plan with strategies to address any specific Aboriginal and Torres Strait Islander health service needs identified.
Risk Rating:
Low
Risk Comment:
The proportion of Aboriginal and Torres Strait Islander consumers in the service is low and the likelihood of adverse outcomes low.

Patient safety and quality systems

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

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

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

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

Not Applicable	

Assessment Team Summary:

The systems for the development, review, endorsement and implementation of policies and procedures is based on the Healthscope systems which are well developed. As stated previously, measurement and reporting are mature and include clinical and non-clinical indicators as well as patient experience/satisfaction. These indicators are monitored locally and by the Governing Body to review against targets and to ensure that variance is managed according to the level of risk of that variance.

Risk management is undertaken utilising the Healthscope risk management framework and systems and there were 151 open risks on the risk register report provided to the assessment team. Reported risks are assessed for the level of risk and the adequacy of existing controls to determine whether further risk management is required. Review dates for each risk reflect the risk level, the adequacy of current controls, and the residual risk. Some review of long-standing risks on the risk register with a view to determine whether the residual risk level is below the level at which the risk is accepted may reduce the number of open risks on the register and make the system more dynamic to emerging risks.

Open disclosure occurs in a formal sense when serious clinical incidents occur and less formally by local clinical teams for less serious incidents. An example reviewed by the assessment team occurred following the retention of a guide wire in an orthopaedic surgical case.

Feedback is encouraged from consumers and is used to review systems and outcomes of care through the clinical governance systems at BPH. Consumer feedback is reviewed and rated to ensure that the actions are taken in a timely way according to the risk level. Corporate KPIs are monitored and reported around the acknowledgement and completion of actions in relation to feedback.

The diversity of the BPH consumer population was reported to the assessment team as predominately English speaking and stable. BPH is required to review the diversity of the consumer population as part of the planning and reporting cycle. As BPH undertake the work around the recommendations in this report for the Aboriginal and Torres Strait Islander community, it may be timely to reflect on any other groups where the proportion is small, but the risk may be greater. For example, those with sensory deficits or other disabilities which impact on equal participation in the healthcare systems provided.

BPH health utilise a fully paper-based clinical record which is comprehensive and available at the point of care and will do so for the foreseeable future. WebPas is the patient administration system and it is evolving to include other functionality. The records are audited for compliance in relation to BPH policy requirements. It was stated to the assessment team during assessment and confirmed through the review of a set of randomly accessed clinical records, that legibility in the record and medications charts was problematic, especially by medical officers. Further, poor documentation also inhibits accurate coding and classification which may have a financial impact and contribute to the attribution of conditions to the facility when they may have been present on admission. BPH is encouraged to develop and implement a system for the review of medical entries in the clinical record, acting where legibility is found to be poor to ensure records are maintained in accordance with the by-laws.

BPH health are well progressed in appropriately accessing My Health Record and providing some limited information into the My Health Record. This is tightly controlled and in accordance with the requirements

and timeframes outlined in the Australian Commission of Safety and Quality in Health Care Advisory AS 18/11.

Suggestions for Improvement:

It is suggested there be review of long-standing risks on the risk register with a view to determine whether the residual risk level is below the level at which the risk is accepted may reduce the number of open risks on the register and make the system more dynamic to emerging risks.

BPH is encouraged to develop and implement a system for the review of medical entries in the clinical record, acting where legibility is found to be poor, in order to ensure records are maintained in accordance with the by-laws.

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:

Training needs for the workforce are derived from performance reviews as well as through other means, such as the needs identified when new equipment is implemented.

Training needs for quality and safety have been identified and this training is provided on appointment through the orientation process as well as in response to incident and adverse event review, the analysis of feedback from patients and carers, and the identification of clinical and non-clinical risks, etc.

Staff educators develop training programs based on these identified needs and provide them both on a scheduled and ad hoc basis as required by circumstances.

BPH has a well-structured performance review process which is conducted annually for all staff except credentialed medical staff. Credentialed medical staff have their performance reviewed on acceptance of their credentialing application and in a structured way after that.

BPH has well developed processes for defining the scope of clinical practice for clinicians and relates that scope directly to the capability of the organisation. This is led by the Medical Advisory Committee (MAC).

The electronic credentialing database is linked to the web-based patient administration system which prevents a non-credentialed clinician from being attached to a patient booking. This is a strong control and allows staff to view whether a credentialed clinician has been allocated. Staff are also able to access and view the database to check the scope for a clinician if they have concerns.

The systems in place for the monitoring of clinical and non-clinical KPIs as well as the case and peer review process are well developed and mature. Unwarranted variation is flagged, reviewed and acted upon.

BPH has been a pilot site in liaison with the Australian Commission for Safety and Quality in Health Care for assessment and overall compliance with the Colonoscopy Clinical Care Standard. BPH has comprehensive systems in place to ensure that all the requirements of Advisory AS18/12 are met.

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	
Met with Recommendations	
Not Met	All facilities under membership
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	
Met with Recommendations	All facilities under membership
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	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

BPH has a large portfolio of buildings and infrastructure of varying age and fitness for purpose. The systems in place for scheduled and periodic maintenance are sound, and the plant and engineering areas assessed were clean and well managed. In spite of this system, areas such as the CSSD and the Endoscopy Unit have had significant issues, which for the CSSD have been addressed.

There are a number of gaps that have been identified by the organisation in relation to workplace health and safety and infection control in the Endoscopy Unit. The unit no longer meets contemporary standards and is no longer fit for purpose.

As a result, Action 1.29 has been assessed as Not Met and a recommendation will be made in Action 3.12 in Infection Control as the recommendation covers both the workplace health and safety and infection control aspects.

BPH has challenges with multiple buildings and a steeply sloping site. Signage and directions are lacking, and the team have all as assessors had to guide lost consumers in the hallways looking for the area they needed to go to. A recommendation is outlined in this report to, in liaison with consumers, review the signage and directions for BPH to ensure that they are clear and fit for purpose.

Some work has been done to create a more welcoming environment for Aboriginal and Torres Strait Islander peoples, especially the great work undertaken by the Damascus Unit. This unit could be a model for other areas as there is a definite gap in a number of areas in recognising the importance of a welcoming environment for Aboriginal and Torres Strait Islander peoples. COVID has certainly delayed the organisation's plans so a recommendation has been made to continue to work with local Aboriginal and Torres Strait Islander communities to identify and develop a welcoming environment for Aboriginal and Torres Strait Islander peoples.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Not Met
Assessor Comment: There are a number of gaps that have been identified by the organisation in relation to workplace health and safety and infection control in the Endoscopy Unit. The unit no longer meets contemporary standards and is no longer fit for purpose. The recommendation will be covered by the one made in relation to 3.12 in Infection Control as it covers both the workplace health and safety and infection control aspects.
Recommendation:
Refer to Recommendation in 3.12 As a matter of priority; a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to: 1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards. 2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed. 3. Increase staff and patient safety through the provision of a safer environment. 4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.
Risk Rating:
Moderate
Risk Comment:
There is increased likelihood of workplace health and safety incidents for staff as well as infection control issues for endoscopy equipment.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Brisbane Private Hospital has multiple buildings and a steeply sloping site. Whist signage is present, it was observed that consumers needed assistance and guidance to the areas they needed to go to.

Recommendation:
In liaison with consumers, review the wayfinding signage and directions for Brisbane Private Hospital to ensure that they are clear and fit for purpose.
Risk Rating:
Low
Risk Comment:
Even though the likelihood is likely, the potential consequences are not significant.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Some work has been done for this action, especially the great work undertaken by the Damascus Unit. This unit could be a model for other areas as there is a definite gap areas across BPH in recognising the importance of a welcoming environment for Aboriginal and Torres Strait Islander people. COVID has certainly delayed the organisation's plans.
Recommendation:
Continue to work with local Aboriginal and Torres Strait Islander communities to identify and develop a welcoming environment for Aboriginal and Torres Strait Islander peoples.
Risk Rating:
Low
Risk Comment:
The proportion of Aboriginal and Torres Strait Islander consumers in the service is low and the likelihood of adverse outcomes low.

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:

Healthscope and BPH have a suite of policies and procedures for partnering with consumers. BPH has developed and implemented a Consumer Engagement Plan 2018-2020 which outlines a number of strategies including:

- the use of consumer consultants,
- consumer approved publications,
- a patient experience strategy,
- bedside handover,
- rounding, and
- compliance with the National Safety and Quality Health Service Standards Second Edition.

This plan has been somewhat successful in partnering with individual consumers in the planning, design and evaluation of care. However, the wider organisational wide aspects of the plan have been more difficult to implement.

There have been recruitment, training and appointment activities to increase the pool of consumer consultants to fill the consumer positions on key committees, however these have been largely unsuccessful. BPH is encouraged to develop a pool of consumer consultants who reflect the characteristics and demographics of the consumer and community population. A pool will also allow some redundancy and succession planning.

As the BPH Consumer Engagement Plan 2018-2020 has expired and the Healthscope document outlined in the self-assessment, the Patient Partners A Consumer Engagement Plan 2016-2019, and the Healthscope Reconciliation Action Plan May 2019 - May 2020 are now all out-of-date and require review and re-issue. This presents an opportunity for BPH to influence the replacement of these key documents and evaluating their BPH Consumer Engagement Plan 2018-2020 in developing its replacement.

Recommendations have been made under 2.11 and 2.13 to address the shortcomings outlined.

Partnering with patients in their own care

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

The systems in place to inform individual consumers of their rights, to ensure informed clinical and financial consent are sound. BPH fully meets the requirements of Advisory AS18/10 Informed Financial Consent. The assessment team noted that some VMOs bring with them the clinical consent on the day of the procedure and the processes vary widely across the VMO group. Discussion and agreement on standard processes for the provision of the consent with VMOs would reduce the potential for failures in the process. If a common process cannot be agreed through the MAC, then standard check processes for those VMOs who bring the consents with them on the day of the surgery should be implemented.

The systems for consent are part of the audit schedule and compliance is reported and acted upon if required. Compliance at assessment was excellent.

Comments in relation to the timeout processes in place at assessment will be made under Standard 6.

Suggestions for Improvement:

Discussion and agreement on standard processes for the provision of the consent with VMOs would reduce the potential for failures in the process. If a common process cannot be agreed through the MAC, then it is suggested that standard check processes for those VMOs who bring the consents with them on the day of the surgery could be implemented.

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:

Healthscope has policies in place for the use of interpreters and the development of consumer approved publications. A register of Healthscope consumer information is available as well as a BPH register of local publications.

Consumer Consultants review any new publications tabled at the BPH Quality Committee and there are specific Healthscope Brochures available for Aboriginal and Torres Strait Islander consumers/families. Damascus Unit has been actively recruiting an indigenous Consumer Consultant and this work is acknowledged and encouraged.

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	
Met with Recommendations	All facilities under membership
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	
Met with Recommendations	
Not Met	All facilities under membership
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:

As stated previously, the BPH Consumer Engagement Plan 2018-2020 has expired and this creates an opportunity to evaluate the whole system in place (including how Healthscope intends to replace their expired strategic guidance documents) in the development of the replacement. Having just one consumer representative for the whole facility (except Damascus) lacks redundancy and succession planning.

It is also difficult for the one-person to be on all the committees intended and to reflect the diversity of the consumer community.

Further, BPH plans have been somewhat successful in partnering with individual consumers in the planning, design and evaluation of care. However, the wider organisation-wide aspects of the engagement plan have been more difficult to implement.

A recommendation has been made in relation to Action 2.11 for BPH to evaluate the expired BPH Consumer Engagement Plan and develop, implement and monitor a replacement which includes how the organisation will sustain the Consumer Consultant Program.

As stated previously in Standard 1 Actions 1.2 and 1.4, BPH does not have plans which outline health service strategies to meet the specific safety and quality priorities for Aboriginal and Torres Strait Islander peoples, which have involved Aboriginal and Torres Strait Islander consumers in their development. This makes it difficult to comply with Action 2.13 and the action has been assessed as Not Met.

A recommendation has been made to consult with local Aboriginal and Torres Strait Islander communities to develop and implement the plan outlined at Action 1.4.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: The BPH Consumer Engagement Plan 2018-2020 has expired and this creates an opportunity to evaluate the whole system in the development of the replacement. Having just one consumer representative for the whole facility (except Damascus) lacks redundancy and succession planning. It is also difficult for the one-person to be on all the committees intended and to reflect the diversity of the consumer community.
Recommendation:
Brisbane Private Hospital evaluate the expired BPH Consumer Engagement Plan and develop, implement and monitor a replacement which includes how the organisation will sustain the Consumer Consultant Program.
Risk Rating:
Low
Risk Comment:
There is a system in place which is not sustainable.

Action 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Not Met
Assessor Comment: The organisation does not have plans which outline specific health service strategies to meet the specific safety and quality priorities for Aboriginal and Torres Strait Islander peoples which have involved Aboriginal and Torres Strait Islander consumers in their development.
Recommendation:
Consult with local Aboriginal and Torres Strait Islander communities to develop and implement the plan outlined at Action 1.4.
Risk Rating:
Low
Risk Comment:
The proportion of Aboriginal and Torres Strait Islander consumers is low, so the likelihood of any adverse outcomes is low.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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

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

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

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

Assessment Team Summary:

The Infection Prevention and Control (IP&C) Committee is multidisciplinary, including a consumer, and is programmed to meet monthly reporting to the Quality Committee. It has been a challenge during the past twelve months due to COVID-19 restrictions for the committee to meet and so meeting have been sporadic over this time. This has resulted in much of the work and the ongoing monitoring occurring external to the meeting and reported by the Infection Control Consultant up through BPH governance committees.

There are comprehensive Healthscope and BPH policies and procedures for healthcare associated infections and antimicrobial stewardship (AMS). Policies are available online and the number of hits can be monitored. BPH has access to e-Therapeutic Guidelines via Healthscope corporate subscription and these are available on all computers throughout BPH.

There is an audit schedule from Healthscope for both Infection Prevention and Control and AMS. There is an extensive audit schedule for IP&C and AMS which includes hospital associated healthcare infections, PPE, Hand hygiene, cleaning, ANTT and AMS is audited through the Surgical National Antimicrobial Prescribing Survey (SNAPS). SNAPS results are shared with VMOs, Heads of Departments and improvement plans discussed as required.

Infection prevention and control systems

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

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

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

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

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

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

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

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

There are processes in place that enable the application of standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the prevention and Control of Infection in Healthcare. This includes policies, audits of workforce compliance with the precautions and ongoing training.

Patients' risk of infection is identified on admission and ongoing throughout their stay. The risks associated with COVID-19 have had significant impact on how this has been undertaken over the past year with additional steps in place to identify patients at risk or those visiting. Intense training of all staff has helped facilitate the implementation in a short timeframe.

BPH has the capacity to isolate any patient as the majority of patient accommodation is in single rooms. There is a risk of only having one negative pressure room and it may be something the organisation needs to consider for future re-developments. There are specific COVID-19 plans in place for Intensive Care and Operating Theatres.

There has been very good compliance with Hand Hygiene compliance at around 90% for all craft groups and disciplines. In addition to this, Aseptic Non-Touch Technique (ANTT) has also a high rate of compliance at around 93% with at least 10% of audits to be of VMO's practice. The link nurses also undertake auditing on appropriateness of PPE. There is a challenge for the organisation to ensure that there is adequate auditors across all areas to maintain the number of audits required for credibility.

BPH has robust cleansing policies and schedules. Audit results and compliance with policies and procedures are very good. If there are issues in cleaning identified retraining processes are put place. Ongoing training of all staff is a regular event and has over the past year been focused on COVID-19 requirements for cleaning. Patient satisfaction is monitored closely, and feedback is provided at the staff meetings. A calling card is left in a patient's room if the patient was not there when the cleaning was undertaken.

There appear to be significant issues in the Endoscopy suite with potential risks from an Occupational Health and Safety and an Infection Control risk plus their ability to meet the AS/NZ 4187:2104. In this area some of the risks are associated with poor ventilation in the clean-up room, cross over of clean and dirty flows, narrow corridors in a fire egress area with trolleys parked in these corridors. This has resulted in a Not Met for this Action.

There has been a large body of work undertaken over the past year on increasing the compliance with a risk-based workforce immunisation program. Processes for new staff are robust but the outlier for the program has been with the permanent staff. The program, which was implemented two years ago to address this group of outliers has had significant improvements going from 56% to now 81% with the target of 100% over the next year. There are also good systems in place to be able to easily access this information should it be required.

Suggestions for Improvement:

It is suggested that strategies be developed to increase the number of staff who are auditors (Link nurses) for each area and make these portfolios manageable in time staff have available.

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

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

Assessor Rating: Not Met

Assessor Comment:

The Endoscopy Suite is currently not fit for purpose. It has been operational for many years and it does not appear to have been maintained and is in need of a review to ensure it is compliant with evolving standards. There are narrow corridors with patient trolleys stored in those corridors. This is an ingress and egress hazard in the event of a fire and can be addressed to a degree by better housekeeping. The ventilation and appropriate air circulation in the cleaning room and procedure room appears not to meet contemporary standards; there is poor segregation of the clean and dirty areas in the clean up room; sterile stock is housed in the general store area and is a walk through area for staff. These latter issues are more difficult to address.

Recommendation:

As a matter of priority, a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to:

1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards.
2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed.
3. Increase staff and patient safety through the provision of a safer environment.
4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.

Risk Rating:

Moderate

Risk Comment:

The issues identified with the Endoscopy Suite are long standing. Even though the issues pose a workplace health and safety and infection control risk, there were no workplace health and safety incidents or infection control breaches identified by the assessment team during assessment. Staff workarounds and tolerance of the workplace health and safety environment has been normalised, and the organisation has demonstrated that they have been aware of the issues for some time and seek to rebuild the unit. In spite of the issues outlined, the likelihood of an infection control breach is unlikely equating to a moderate risk.

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	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

There has been a significant investment and body of work to upgrade and ensure that the CSSD has the capacity and meets the requirements of reprocessing of reusable medical equipment, instruments and devices used in the theatre complex. This unit is now able to meet the relevant standards particularly AS/NZ 4187:2014. The unit is well designed and with good flows for the movement of instruments and devices through the reprocessing cycle. The system for enabling the traceability of the process for critical and semi critical equipment is in the final stages of implementation and should be online by the end of February.

Despite this significant investment there has been minimal work done to ensure that the Endoscopy suite meets the full requirements of AS/NZ 4187:2014. There was an external consultant who reviewed the Endoscopy suite in August 2020 but there was with no report received until the later part of the assessors visit. The report received was very brief and incomplete.

This issue of potential cross contamination of scopes has been on the Risk Register since 2013. Despite the poor flow of clean and dirty equipment with cross over and only one door for entry and exit with dirty and clean instruments the control hierarchy has been assessed as 'Good' by the organisation. As the requirement of the Advisory 18/07 states that the Gap Analysis is due for completion by June 2021 the Action has been rated as Met with a Recommendation.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Despite the NSQHS Advisory 18/07 for 'Reprocessing of reusable medical devices in health service organisations' which addresses the new AS/NZ 4187:2014 being in place for the past three years there has been little evidence up till now of any gap analysis undertaken with a plan for the Endoscopy suite. A very first draft of the plan for Endoscopy was presented to the assessors late in the survey which is not complete. Apparently, an external consultant had visited in August 2020 but no report had been received up until the survey. There is a significant body of work to be completed in this area but due to COVID the timelines for the requirement for this action have been extended thus a rating of Met with Recommendation has been given. As for the rest of the organisation where this is a requirement this has been addressed. This is evidenced by the CSSD area which now meets the requirements of the Advisory with the near completion of the fully refurbished CSSD.
Recommendation:
As a requirement of the Advisory 18/07 Version 6.0, 1. a Gap analysis be completed for Endoscopy by June 2021, 2. an implementation plan be developed, documented and endorsed by Executive by December 2021, 3. the plan be progressed to be completed by December 2023 according to the Advisory 18/07.
Risk Rating:
Moderate
Risk Comment:
The requirements of the Advisory 18/07 for a Gap Analysis is not required for completion until June 2021. Even though the issues pose an infection control risk, there were no infection control breaches identified by the assessment team during assessment. Staff workarounds and tolerance of the workplace has been normalised, and the organisation has demonstrated that they have been aware of the issues for some time and plan to rebuild the unit. In spite of the issues outlined, the likelihood of an infection control breach is unlikely equating to a moderate risk.

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:

Locally, the governance for AMS at BPH has been via the AMS Committee which has a multidisciplinary membership and is still in formative process of establishing itself over the past 12 to 18 months. There has been challenges in holding the meetings occurring due to COVID over this time. Despite this between the EPIC Pharmacist and the Infection Control Consultant and with the support, when required, of the Infectious Diseases Physician the policy has been implemented and monitoring put in place. The Meeting is to be held quarterly and chaired by a medical officer.

The AMS Policy is based on a traffic light system to determine restrictions and there is AMS rounding occurring by the EPIC pharmacist when available. Information is available to staff on the HINT site.

Audits conducted include Surgical National Antimicrobial Prescribing Survey (SNAPS) and National Antimicrobial Utilisation Surveillance Program (NAUSP) with the later in early days of being collected. The Sepsis pathway has been reviewed and rolled out as part of the Coroners findings.

Currently, the monitoring antibiotic usage is undertaken by the pharmacist and infection control Coordinator, but the plan is to establish Link AMS nurses who will have this as part of a portfolio. This portfolio will particularly focus on rolling out education for the nursing staff in regard to the policy and traffic light system and what is their role in monitoring and compliance with the policy.

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:

The governance structures for medication safety are provided by the National Medications Safety Team and this filters down to Brisbane Private Medication Committee. Membership of these committees is multidisciplinary, and these committees provide expert oversight of the policies, processes and improvement activities in medication safety. There is strong evidence that information and issues from these committees filter down into various craft groups, the MAC and the PCRC.

National Policies are available on the intranet to access and at assessment staff could demonstrate how to access these policies in a timely way.

The governance structures also monitor medication related incidents, which provides the opportunity for shared learnings at both Brisbane Private and Healthscope National.

There are clear processes guiding the prescribing and use of off-formulary drugs, individual patient use drugs, and unregistered medications, however it is suggested that Brisbane Private review the process for prescribing and administering homeopathic drugs to offer clear direction to clinical staff.

Supply is delivered by EPIC, a contracted service who are co-located on-site. This service is highly valued by the clinicians and it is obvious that the strong relationship has resulted in positive outcomes for medication management. The EPIC service provides valuable education and training opportunities for clinicians, and produces a safety report every meeting for the Medication Committee. It was also very reassuring to see that there was a policy for Escalation of Clinical issues that was robust and directive.

Med+ Safe is the online e-learning program that is utilised by all Healthscope facilities to support medication management training and training rates at Brisbane Private show good compliance. Supplementing this has been various training for medication management, including recent training on Alaris syringe pumps.

Suggestions for Improvement:

It is suggested that Brisbane Private Hospital review the process and policy for prescribing and administering homeopathic drugs to offer clear direction to clinical staff.

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:

Concerted effort has been made by Brisbane Private by to improve compliance with obtaining a Best Possible Medication History (BPMH) on admission. The assessors confirmed that staff working pre-admission and admission, actively engaged with the patient's GP as well as patient and carers to clarify ambiguities and to obtain the BPMH. It is however noted that audit results for 2020 show a 30% decline in the medication history documented on the chart or elsewhere and cross referenced with the chart. It is suggested that BPH continue to work on this to lift compliance back to previous levels.

Allergies and adverse drug reactions are well documented. Adverse events are reported on the incident management system, reported via the governance structures and there is a mechanism to escalate ADRs to the TGA.

Suggestions for Improvement:

It is suggested that BPH continue to focus on improving compliance with medication history documentation to ensure return to previous benchmarked levels.

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:

There is a robust continuity of Medication Management process at BPH that is managed by the pharmacists with input from nurses and medical staff.

The National Standard medication charts are in use and reviewed by pharmacy staff and there is a policy on escalation of clinical issues related to the dispensing of medicines.

Patients that are high risk will receive a medication profile on discharge and are educated on the content. This profile has two versions, a longer version that gives detail of the medications and a one-page summary. A signature is obtained from patients/carers to verify they have been counselled on the contents. The clinicians and patients on survey expressed that the service provided was timely and well understood. The orthopaedic unit are to be congratulated on their quality project to ensure the return of patients own medications on discharge, this is a consumer-focused initiative.

It was noted on survey that many of the patients in the Damascus Unit were on 5 medications or more and required comprehensive medication management plans and profiling. Currently, the pharmacists receive referral for review from nursing staff however resource allocated has been reduced from twice per week to once per week. It is suggested that a risk assessment be completed on the number of high-risk patients (on average) in Damascus to ensure that timely review and medication profiling is adequate on this schedule.

Suggestions for Improvement:

It is suggested that a risk assessment be completed on the number of high-risk patients (on average) in Damascus to ensure that timely review and medication profiling is adequate on this schedule.

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:

To ensure decision support tools for medicines are available to clinicians, Brisbane Private Hospital has access to tools such as e-Therapeutic Guidelines and e-MiMS via the Healthscope Intranet (HINT). The list of tools currently available is robust and comprehensive.

Medications are accessed by contracted agreements with EPIC. Formulary items are supplied according to a well-defined inventory system. All medications are stored in appropriately secured areas, with protocols for managing S8 and S4D medications as well as cold chain management.

There was some discrepancy with maintenance of the S8 and S4 registers, depending on the clinical area and it is suggested that BPH carry out a comprehensive audit of DDA books to ensure that practice is consistent, particularly for carry forwards, discrepancy reporting and discards.

It was noted that there was good compliance with daily cold chain auditing.

Disposal of unused and unwanted medications was well managed, as was the return of stock items to pharmacy. It is suggested that BPH audit the discard process in operating theatres to ensure compliance with best practice.

High-risk medications are flagged alerting clinicians to follow the high-risk medication protocols. There were no incidents resulting from these high-risk drugs recorded in the incident management system.

Suggestions for Improvement:

It is suggested that BPH carry out a comprehensive audit of DDA books to ensure that practice is consistent, particularly for carry forwards, discrepancy reporting and discards.

It is suggested that BPH audit the discard process in operating theatres to ensure compliance with best practice.

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	
Met with Recommendations	All facilities under membership
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:

A comprehensive suite of Policies/ Procedures and Guidelines, as part of the governance structures, is in place to guide staff in their delivery of comprehensive care. There are relevant and appropriate governance systems implemented to support clinicians to deliver comprehensive care which is congruent with evidenced practice across BPH. However, in relation to clarity regarding the governance of Standard 5 at BPH, it appeared that sections of it were discussed at Quality committee, but it was difficult to identify a committee focusing on the improvement of comprehensive care. It is noted unlike other Standards 3, 4 and 8 there was no committee established to govern Standard 5.

Considering the expansive breadth of Standard 5 and that many of the indicators in Standard 5 are "nurse sensitive" indicators, it is suggested that this discipline drive a committee to govern the work in Standard 5. This should ensure that Standard 5 has a committee that is structured with definitive lines of reporting and delegated responsibilities to ensure it has governance oversight of the quality improvement program across the service. This Comprehensive Care Oversight Committee should articulate a reporting schedule together with the necessity of the provision of action plans in response to areas where non-compliance has been noted. This committee should have a reporting function to the PCRC.

The Damascus Unit's primary core business of managing Alcohol and Drug Addiction creates challenges for the development of a meaningful comprehensive care plan template as currently the proforma does not directly align and synergise with either an acute or mental health care map and plan.

This is well recognised by clinical staff who have trialled several different versions of a care plan since 2017. Despite robust PDSA cycles and evaluation in 2021, there is still not an endorsed pathway and care plan, even though there have been a number of attempts to introduce quality improvement changes through executive and Healthscope National. it is recommended that the templates for undertaking

Comprehensive Care plans in the Damascus Unit be developed and endorsed in a timely manner to provide purposeful, individualised patient care that is targeted at the primary diagnosis.

A comprehensive Audit program is readily available to ensure monitoring of clinical practice against evidenced based policies, procedures and guidelines occurs. The comprehensive care audit schedule forms part of the quality improvement program. Feedback on performance is provided to some relevant committees and information flows back to frontline clinicians, however this would be strengthened by the above approach.

Risks are identified via a variety of assessment tools with strategies implemented to mitigate risks. Mitigation strategies are clearly articulated and there is clear indication that larger risks are reviewed at the highest level of governance.

Staff educational needs have been identified and appropriate training sessions are implemented to ensure staff are well versed with expectations and ways in which comprehensive care is expected to be delivered. Patients' needs and levels of risk are identified via the risk screening and assessment tools available to staff. A range of data is collected from the screening assessment and is used to monitor performance and augment quality improvement activity. Key performance indicators and clinical indicators data are also obtained via the RiskMan systems, clinical audits, non-clinical audits, Morbidity and Mortality committees to measure a range of services provided and benchmarked between Healthscope services, and against peer hospitals. Reporting is in line with the reporting schedule articulated by governance structures. Quality improvement activities are captured via a Quality Improvement Register which acts as the repository.

Feedback is obtained from patients and clients on a regular basis and used to improve the delivery of comprehensive care. In particular, the models of care in Damascus and Paediatrics have been bespoke to ensure consumer engagement and involvement obtained is articulated in goal setting and management plans.

Referrals from BPH provide comprehensive information to ensure safe care and appropriate services are aligned to meet the needs of individual clients. Additionally, many wards have multidisciplinary meetings that co-ordinate referrals in a timely and efficient manner. A good example was the MDT held in Rehab ward driven by Dr. French.

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

Suggestions for Improvement:

It is suggested that consideration be given to Standard 5 having a local committee that is structured with definitive lines of reporting and delegated responsibilities to ensure it has governance oversight of the quality improvement program across the service. This committee would report to PCRC.

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

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

Assessor Rating: Met with Recommendation

Assessor Comment:

The Damascus Unit's primary core business of managing Alcohol and Drug Addiction create challenges for the development of a meaningful comprehensive care plan template as they do not directly align and synergise with either an acute or mental health care map and plan.

This is well recognised by clinical staff who have trialled several different versions of a care plan since 2017. Despite robust PDSA cycles and evaluation in 2021, there is still not an endorsed pathway and care plan, even though there have been a number of attempts to introduce quality improvement changes through executive and Healthscope National.

Recommendation:

The templates for undertaking Comprehensive Care plans in the Damascus Unit be developed and endorsed in a timely manner to provide purposeful, individualised patient care that is targeted at the primary diagnosis.

Risk Rating:

Low

Risk Comment:

Risk rated low as a draft form has been in place since 2017 that creates some direction to care.

Developing the comprehensive care plan

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

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

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

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

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

Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Policies and processes ensure that a paper based comprehensive clinical, cognitive and social assessment is undertaken at admission identifying reason for admission and patient risk. Further assessment is undertaken within specified time frames of the policy with care plan audits demonstrating a high compliance (trending above 95%).

Admission documentation across all services includes risk triggers to identify need of in-depth assessment for all areas of risk identified.

There is a process for documenting ATSI patient status, and staff have been trained using a video titled "Asking the question". Reports were available on identification numbers.

On admission a paper-based comprehensive screening is undertaken on all patients using validated assessment tools and is ongoing through the episode of care. Physical, cognitive, social and cultural history, issues and risks are identified and documented. From this a comprehensive multidisciplinary care plan is developed utilising initial admission documentation, clinical notes from the treating doctor and allied health staff with input from the patient and family to identify patient goals. There has been concentrated work by Healthscope to create a four-page fold out form. This replaced 10 single sheet pages and has been evaluated as a more user-friendly tool by clinician. Currently, the care plan is primarily

owned by nursing staff and it is suggested that Allied Health and medical practitioners should have a more active role in this document going forward.

The recent introduction of the 4AT screening tool is a good step towards identifying delirium early ensuring appropriate care is able to be provided. Follow up audits will demonstrate its effectiveness and it is suggested that the PDSA cycle continues around the delirium work to consolidate it at BPH.

There is a process for making ACDs available in the clinical record and ACDs were witnessed to be present during assessment.

Suggestions for Improvement:

It is suggested that:

- As the comprehensive care plan continues to develop there be more input into the documentation from Medical and Allied Health staff to make it a truly multidisciplinary tool.
- Follow up audits be undertaken on the 4AT screening tool to consolidate it at BPH.

Delivering comprehensive care

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

The comprehensive multidisciplinary care plan is maintained and used by clinicians to provide care and assess ongoing needs of the patient. Care plans of long stay patients are reviewed at weekly multidisciplinary meetings as to their effectiveness or reviewed and updated with changes in patient needs and condition. The care plan is completed in consultation with the patient and family is appropriate with the patient signing for the care provided ensuring participation in planning and provision of care. This commences with the HMR 6.13E that is completed on admission. This form articulates the shared goals between the treating team and patient and carers.

Specific care, treatments, diets, examinations and tests are noted on the patient whiteboards. Audits on care board compliance and use as a tool for communication with updated information, show variation across BPH and this was also evident to the surveyors on survey. It is suggested that BPH review the intent and content of the communication boards to ensure they truly reflect a patient centred tool rather than staff focused tool. It is also suggested that BPH could use these communication boards to communicate what matters to the patient for that moment in time to build patient centred care. Posing the question "What matters to you on the board" could aid in developing the exemplar customer service BPH is striving for.

The referral/pre-admission system into BPH and for discharge is supported by role specific nurses who integrate well into the MDT teams and appear to assist to create a more seamless journey for patients. A process is in place for the immediate escalation of Mental Health patients to appropriate care facilities.

The Healthscope last days of Life Toolkit (adapted from the CEC) is consistent with the National Consensus Statement are available to assist in the identification and care for patients at end of life. Staff are trained to discuss end-of-life care with patients and family to enable shared care decisions to be made, supported by the information package and specialist clinical information.

BPH has an EOL brochure to assist staff and patients that was readily available throughout BPH.

Suggestions for Improvement:

That BPH review the intent and content of the communication boards to ensure they truly reflect a patient centred tool rather than staff focused tool; it is also suggested that BPH could use these communication boards to communicate what matters to the patient at that point in time to build patient-centred care.

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	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

Not Applicable	

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

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

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

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

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

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

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

Assessment Team Summary:

Healthscope have an established national committee to provide oversight of the pressure injury prevention and management objective.

Evidence based guidelines have been utilised to support staff in the prevention and care of persons at risk, or with a pressure injury. The framework incorporates Healthscope policy directives and tool kits, guidelines and screening and assessment tools. The system is well structured, comprehensive and accessible to staff. The use of, and compliance with the documents within the framework are monitored through a range of scheduled audit activities which are reviewed at national, site and unit level.

Compliance is very good, and it is noted that BPH reported no pressure injuries for the July-September 2020 period.

Patient and carers are provided information about preventing and managing pressure injuries throughout their episode of care. Information is provided at point of care across the care continuum and also in the provision of printed materials endorsed by Healthscope. Patients surveyed indicate that they were engaged in their treatment and provided information about their care.

Products, equipment and devices are available to prevent pressure injuries and nurses could articulate how to access these if required.

Evidence-based guidelines have been utilised to support staff in the prevention and care of persons at risk of a fall. It is noted that Healthscope were successful with some other partners in gaining a Falls research grant from NHMRC to explore different approaches to falls management. A formal evaluation was undertaken to ensure removal of numerical assessment did not result in an increase of falls. This evaluation noted that the fall rate trended the same regardless of which assessment was chosen and Healthscope have consequently adopted the new approach.

It was noted that while there was obvious alignment with Best Practice Guides, there are also some deviations, particularly around the use of flagging and alert systems outside of the clinical record to engage all staff, families and carers at BPH and make safety everyone's business. Consequently, it is recommended that a comparative review be undertaken of current practice for the management of falls at Brisbane Private Hospital and the Best Practice guidelines provided by the Safety Commission: Preventing Falls and Harm from Falling. Particular attention should be focused on flagging alerts page 99.

Compliance is monitored and reported through site and national clinical governance committees. When benchmarked, BPH currently are in the lower third of falls data amongst their peers and there is real opportunity for them to become the exemplar service and transition from "good" to "great".

Equipment and devices are readily available, and staff are trained in their use. Patient mobility aides, sensors mat and patient movement alarms compliment the list.

Patient and carers are provided information about falls prevention throughout their episode of care and other than the brochure there are posters and TV education options.

Nutrition and hydration management procedure and policies and Food Service Menu manual provide operational support for staff optimizing nutrition to promote well-being, recovery and the prevention of malnutrition. It was noted on survey that MST completion had high rates.

Food and nutrition services are provided by appropriately trained staff with clear roles and responsibilities assigned according to role delegations and scope of practice.

The experience of the surveyors at BPH indicated that the food for patient meals was at an exceptional standard and many patients commented on the quality and presentation of patient meals.

During site visits, it was noted that patients' mealtimes were often disrupted and access to staff limited. It is suggested that for high risk patients, improving the environment in which is food consumed through the implementation of protected meal times be considered.

Healthscope National provide the overarching policies and processes for BPH to manage persons with delirium or cognitive impairment. Delirium and cognition screening and assessments (CIRAT, HMR 6.27 4AT) occur on admission. If a positive screen is identified the pathway for referral are clear through the Delirium flow chart. Carers are engaged in care as required and the Family Carer consultation form provides a tool to formalise their engagement.

Pharmacy services support pharmacological review and management across BPH. There are a range of initiatives to improve the management of persons with cognitive impairment and reduce harm associated with cognitive impairment that were evidenced across the service. Recent training sessions in 2020 have been evaluated.

Whilst the HAC associated with Delirium is trending well at BPH, the additional training that has now occurred may lead to increased reporting. It is suggested that BPH continue to monitor the results through their local governance structures and respond accordingly.

Screening for self-harm risks commences at point of entry into the service. If a positive screen is identified, the pathway for referral, secondary assessment and ongoing care is articulated. Care planning is individualised, safety orientated and documented in the medical record.

In the general hospital setting referrals are currently made to specialist mental health, or primary care services as required.

There have been some educations sessions focused on the assessment of mental health. There is an opportunity to review the training provided to staff across BPH care settings to ensure that the clinical workforce has the skills and knowledge to engage collaboratively with persons (and their families) identified at risk of harm. A suggestion is made to formalise the organisations education and training program for all staff across the elements described in Action 5.31 to increase awareness and capability in the identification and management of persons at risk of self-harm or suicide.

Monitoring of the system is via self-reported incidents, clinical reviews, mortality and morbidity meetings and patient feedback. Incidents relating to self-harm on site have been recorded. Such incidents have been formally reviewed and action has been immediate and well managed with referral off to appropriate mental health services.

BPH access the Healthscope's OHS Safety Portal that has the strategies and associated policies and toolkits provide support to the clinical workforce on the prevention and management of challenging behaviour, violence and aggression. Oversight is provided by the Workplace Health and Safety Committee.

Risks of aggression and violence are minimised by reducing environmental and procedural triggers for aggression. Exemplars include the adoption of sensory modulation techniques, and nurse specialling for vulnerable persons.

The identification of potential aggressive and/or violent behaviours is identified during the admission assessment or throughout the episode of care using a service specific risk assessment form. Such risks and associated care plans are entered into the body of the clinical record.

WAVE Training is undertaken by staff and areas are risk rated to establish the type and extent of training required. Compliance is high. Personal duress alarms are available to staff working in high risk areas. Code Black is utilised for personal danger situations.

Limited evidence was cited during the assessment of patient, carer and family feedback regarding their participation in treatment planning for aggression and violence and a suggestion has been made to incorporate this into system.

Seclusion is not an endorsed practice in the general health care setting and BPH does not have state mental health beds. Consequently, improvement initiatives across service have focused on minimising the use of restraint and seclusion and include enhanced communication skills, the use of and the creation of safe places for vulnerable persons. This was particularly evident in the acute Damascus Unit. It is noted that BPH has recorded no physical restraint but rather just the use of chemical and monitoring strategies.

There is a Healthscope Restrictive Practices policy in place. Performance indicators have yet to be developed to measure compliance and use of chemical / monitoring strategies and it is suggested that this be considered.

Suggestions for Improvement:

It is suggested that:

- For patients at high risk of malnutrition, improving the environment in which is food consumed through the implementation of protected mealtimes be considered.
- BPH continue to monitor the 4AT audit results through their local governance structures and respond accordingly.
- the organisation's education and training program for all staff be formalised across the elements described in Action 5.31 to increase awareness and capability in the identification and management of persons at risk of self-harm or suicide.
- with limited evidence cited during the assessment of patient, carer and family feedback regarding their participation in treatment planning for aggression and violence, a suggestion has been made to incorporate this into the system.
- Performance indicators be developed to measure compliance and use of chemical / monitoring/ specialling strategies.

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

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

Assessor Rating: Met with Recommendation

Assessor Comment:

Brisbane Private Hospital has tools and processes in place to identify, assess and manage those patients at risk of falling. Documentation audit results show good compliance with risk assessment and management.

There were, however, some discrepancies noted with clinical practice and best practice guidelines currently available for Preventing Falls and Harm from Falling.

Recommendation:

A comparative review be undertaken of current practice for the management of falls at Brisbane Private Hospital against the best practice guidelines provided by the Safety Commission: Preventing Falls and Harm from Falling. Particular attention should be focused on flagging alerts.

Risk Rating:

Low

Risk Comment:

Brisbane Private Hospital has a form of assessment and care planning for patients at risk of falls, however a comparison with gold marked practice would ensure a benchmarked standard.

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:

BPH follows the Healthscope policies and procedures that support systems for the effective and timely communication of clinical information. There are several key policies and guidelines provided by Healthscope on all aspects of communicating for safety, including handover, patient identification and procedure matching.

Healthscope has a group of quality measures in place and executive sponsorship is held by the Director of Nursing. In addition, BPH participates in the Healthscope Shared Learnings Program which provides an avenue for sharing the experiences and any lessons from other sites which are then incorporated into BPH Quality and Risk Program.

Clinical handover training is a mandatory requirement and training is done via an online platform and if required, a hands-on approach by the hospital educator. Staff have access to educational videos via the Healthscope Intranet (HINT). This is supported with a focus on 'Back to the Bedside' as the focus of engaging with the patient.

Monitoring the effectiveness of communication for patient safety includes audits of the patient clinical records, evaluation of patient surveys, review of RiskMan Incidents, complaints management and the audit of bedside clinical handover. Audit outcomes are communicated to staff at Ward Meetings, Patient Care Committee, Clinical Meetings and through the Quality Manager to the Executive.

Quality improvements have included such activities as a cheat sheet, and flask cards for the "Huddle" and ISOBAR handover processes. In addition, the use of a standardised handover sheet printed from WebPas also helps to ensure information is standardised and in the agreed format.

BPH demonstrated effective systems for the transfer of patient information. There were systems in place for timely and accurate transfer of clinical information from the patient admission to discharge, including examples of referrals to other facilities, the VMOs, General Practitioners, and emergency medical evacuations.

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	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope policies prescribe that every patient has three identifiers which are routinely checked and confirmed throughout the patient's health care journey - from admission to discharge.

Patient registration information is obtained on admission to the health service and this procedure requires that at a minimum three prescribed identifiers are recorded for every patient. Patient Identification bands comply with the Standard requirements and only white or clear armbands are used unless there is a medication allergy risk, when it is red, as per policy.

There are many checkpoints throughout the patient journey to confirm patient identification and it was observed that this is generally well done. Nursing bedside clinical handover was observed in the majority of clinical areas and noted that the three identifiers were checked at the commencement of each communication. Audit reports confirm high compliance with the checking of the patient's identification.

There are well established systems for the obtaining of patient consent prior to procedure and in the various settings in which this occurs. BPH operating theatres described examples of the patient journey from registration and consenting for procedure; discharge planning; patient and family support; and post-discharge follow up. The Surgical Safety Checklists audit results confirmed compliance with the obtaining of patient consent and that the majority of patients were matched with the consented procedure. The assessors were able to observe an incident regarding consent for a procedure which was picked up in the early stages of preparation for theatre. This was discussed between the VMO and the patient prior to

proceeding and options were provided and the case was postponed to the following day. The patient was pleased with the outcome and felt comfortable with the systems in place to ensure her safety.

There have been sentinel events with two wrong site surgeries occurring in the past twelve months which are discussed at the Orthopaedic Morbidity and Mortality meeting and outcomes were discussed at the relevant Clinical Governance meeting and referred to the Patient Care Committee for the implementation of the recommendations. The assessors did not have access to the full reports as they were internal reviews.

It should be noted that the assessors also noted a discrepancy in the Policy regarding 'Time-out' against the Audit tool. The language is not consistent and the whole team doesn't always fully 'stop' (policy) during the 'Time-out' process but are 'present' (audit tool). There is a recommendation in the report in regard to this issue to assist in full compliance with the policy and to attempt to prevent the reoccurrence of a wrong site surgery. The discrepancy can also give a false compliance audit result against the policy.

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
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: It was evident to the assessors that there is a timeout process in place across all areas where relevant. There is an issue with the definitions and language utilised between the Healthscope Policy which states the team must "stop" and the Audit Tool which talks about being "present". As there have been two wrong site surgeries in the last twelve months, it is important that all areas of the process are adhered to by all of the team all of the time. It was observed in one theatre that some staff were not totally engaged in the process of 'timeout' as a whole team, however depending on one's interpretation of the definition of present – it could be perceived as complying. In other cases, there was extremely good compliance with the intent of 'Timeout'.
Recommendation:
1. The language in the policy and audit tools used for 'timeout' be aligned with clear definitions and education be provided to facilitate compliance. 2. The 'timeout' process in all theatres and procedure room fully comply with the intent of the policy which is measured by a revised audit tool.
Risk Rating:
Moderate
Risk Comment:
There have been two investigations into the two wrong site surgeries and strategies have been put in place to address the issues determined to be causal factors. The management of the unit are working to address the issues of the policy and audit non-conformity and instigate a "pause" process. Due to this work, the risk has been rated as Moderate.

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:

Clinical handover at the bedside is planned, scheduled and managed by the shift coordinator. To meet the requirements of different areas and specialities there are variances to how the staff briefing occurs prior to the bedside component commencing. These may include a Team Huddle, Manager Briefing and/or may be multidisciplinary. Patients are supported to document questions for their treating clinician and with outcomes and/or changes recorded in the Care Plan. The nursing Patient Bedside Clinical Handover is well managed, consultative and with patients engaged in the process. The Operating Theatres demonstrated consistently high audit results for their ISOBAR Clinical Handover process.

Patient rooms have whiteboards (Care Boards) to record patient information, patient goals, family information etc. The nursing shift change Clinical Handover at the bedside utilises the ISOBAR methodology where patient identification is checked, patients/family/carers invited to share information and ask questions. Daily VMO ward rounds occur with a nurse involved where possible. Patients also confirmed with the assessors their confidence and inclusion in the planning of their in-hospital care, discharge planning and their post discharge management.

At orientation BPH's clinical staff receive an ISOBAR handover ID card, to assist in following the process and all staff receive ongoing education on ISOBAR. Staff involve the patient and carers if present in the beside handover. Bedside handover occurs 2-3 times in a 24-hour period depending on the length of the shift hours.

Planning for Patient Discharge commences on admission and with the patient information updated throughout the patient journey. Patients are invited to provide feedback on their discharge experience post discharge and which then informing changes and improvements to the process. Patient transfer, consulting VMOs, multidisciplinary teams and/or discharge to another service is consistent with the ISOBAR methodology.

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:

BPH demonstrated processes to the assessors that ensure critical information is communicated between clinicians and from patients and carers as required. The suite of forms assisted staff to do this. The Cheat sheets and flash cards prompts the communication between clinicians to be structured in the ISOBAR format. The bedside handover and the care call process, which encourages patients and carers to escalate concerns to staff, are strategies that the organisation supports patients and families to communicate critical information to the staff during their admission.

Open disclosure policies and guidelines are in place to guide clinicians in the process in a timely manner.

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:

BPH has a paper-based system for their medical record. The organisation has appropriate medical record forms to support the staff in maintaining contemporaneous notes on patient care. Evaluation of the Patient Clinical Record Clinical Handover documentation confirms good compliance. Audits are scheduled in the auditing program for ensuring contemporaneous reporting and with a re-audit scheduled when actions for improvement are identified and completed.

An issue was identified by a number of people in the organisation around the legibility of some of the VMO's writing. This can cause a number of issues from a coding perspective to potentially the wrong medication being given. It is suggested that the issue be referred to the Medical Advisory Committee for their advice and direction in improving this issue.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

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

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

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

Assessment Team Summary:

BPH has policies and guidelines developed by Healthscope and is aligned to the national evidence-based guidelines for the safe, appropriate prescription, administration and management of blood and blood products. Healthscope provides the organisation-wide clinical and scientific leadership and the training framework regarding blood-related matters.

Locally, the governance of blood management was through the Transfusion Committee (TC) prior to COVID which prevented meeting attendance by a number of members and the committee is now being merged into the Perioperative Committee. The Terms of Reference, membership and agenda are all

currently being reviewed. The committee has been and will continue to be multidisciplinary, meet on a bi-monthly basis and is an expert advisory group for patient blood management matters to Brisbane Private Hospital.

It is extremely important that this new merged committee be revamped and activated in its new format as soon as possible. This needs to include processes to ensure that the appropriate people are available and attend and that the issues of Blood and Blood Products are not overwhelmed by other issues associated with the Perioperative Committee. An evaluation process should occur at six and then annually to ensure that the issues and monitoring continue to be tabled and addressed.

The Blood Management Committee had met bi-monthly prior to COVID, with memberships from VMOs, both external pathology services (with Laboratory scientists the nominated representatives QML, Sullivan & Nicolaides, NUM, Executive and Red Cross representatives. Blood and blood product incidents are reported through this committee and documented. Lessons learned from incidents and relevant data for each facility in Healthscope regarding blood use is shared and benchmarked against similar sized hospitals in the broader organisation.

Transfusion audits are on an audit schedule and despite COVID have continued to be conducted. Outlier audit results are added to the quality action plan if required and a re-audit is facilitated.

Issues raised in 2018-2019 at the Transfusion Committee about blood availability, monitoring and storage resulted in a new blood fridge being commissioned in August 2019 in a secure location. The temperature checks and alarm testing has provided an easier checking and monitoring process. New processes have been put in place with associated education and has resulted in an increased level of confidence in safe storage and access to these products at the BPH. The blood fridge and blood register are audited six-monthly by an external pathology company.

With the establishment of the new blood fridge a new Massive Transfusion Management protocol was introduced that included large posters for staff to highlight succinctly the process and enable them to quickly follow the it in an emergency. This has received extremely positive feedback as these incidents occur rarely it is important to enable staff to appropriately respond with tools that support their practice. This also included competency training and inclusion in orientation. In July, BloodSafe (transfusion) Compliance was 97%.

A new Blood and Blood Products Prescription and Transfusion Record was Implemented 2019 this form includes tick boxes for staff and VMO to record that they checked the informed transfusion consent, indications for transfusion, and time out for the administration, involving the patient in the process. These charts are audited and then benchmarked across Healthscope with results available to staff on HINT and the significant lessons learnt are shared across Healthscope quarterly.

Clear processes are in place for gaining consent from the patient and the processes for ensuring the patient has consented prior to transfusion appears to be embedded into the organisation with audit processes in place to monitor this occurs.

Suggestions for Improvement:

The Transfusion Committee component of the Perioperative Committee be closely monitored and have clear KPIs so that its intent and the key stakeholders and experts continue to be involved.

Prescribing and clinical use of blood and blood products

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

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

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

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

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Blood management strategies are in place to ensure that the use of blood products is appropriate and safe, and strategies are used to reduce the risks associated with transfusions including a TEG6 Machine (a whole blood coagulation analyser).

Relevant documentation of known patient's history, indications for transfusion, special product or transfusion requirements, type and volume of product transfused and any response to transfusion is comprehensive and is documented. Pre-admission assessment by the Clinical Care Coordinator for surgical patients includes assessment and management of anaemia pre-operatively.

There is a blood transfusion/blood product administration consent form and an information sheet (based on the Australian Red Cross Blood Service information sheet) is provided to the patient when consent is being discussed. This provides information on what the doctor will do, what checks will be undertaken, how long it will take and what happens if the patient has a reaction to the product. The consent form has a section for the patient to acknowledge that they have received this fact sheet. Audits of information documented in the patients' records occur and include consent.

There is good process in place to keep the VMOs informed of any changes to procedures regarding blood management including a letter from the Committee Chair in regards to ensuring patients are worked up according to needs. In addition, there has been a move towards increasing the number of Group and Hold rather than the previous practice of most patients receiving a Group and Crossmatch. A preoperative call is made to the patient by the hospital Clinical Care Coordinators to identify patients who may be at risk of bleeding so appropriate actions can be taken to minimise the risk.

Managing the availability and safety of blood and blood products

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

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

Assessment Team Summary:

There are clear processes in place for the receipt, collection, transportation, and storage of blood and blood products within the facility that is consistent with best practice. Training is provided to staff involved with the collection and transportation of blood and blood products.

Haemovigilance includes Massive Blood Transfusion Protocol (which includes posters, emergency blood and blood products), TEG6 use in Massive Blood Transfusion procedure, emergency mobilisation pathways, IV iron procedure and prescriptions, blood transfusion record sheet, (includes bedside check, suspected transfusion reaction), specimen collection and labelling.

BPH achieves wastage reduction through standardised procedures; blood stewardship; blood fridge maintenance; cold chain security; procedures for packing and unpacking; systems for returning blood units; committed partnerships, audits and education. Inventory for blood products is managed by QML Pathology and is recirculated where possible to avoid wastage. This is monitored through the Transfusion Committee.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

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

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

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

Assessment Team Summary:

There are various policies and procedures from Healthscope National and BPH to support recognition and response systems for the deteriorating (R-RAD) patient.

There are also Standard 8 governance committees at both a BPH (Rapid Response Group) and National level. Reports from like services are tabled at these meetings that promote benchmarking of key quality indicators.

All patient incidents related to recognising and responding to deterioration are recorded, managed, investigated and analysed via the RiskMan system. Incidents are then collated and discussed monthly by the Rapid Response Group (RRG).

The 4AT Cognitive Impairment Assessment tool has been implemented and this will further support recognition and response processes to cognitive deterioration. It was noted that education about deteriorating cognitive condition has recently been a focus at BPH.

There was evidence that Medical Emergency Team (MET) responses are audited internally, benchmarked with other Healthscope services and by ACHS indicators. BPH was not a negative outlier in any of these indicators. During assessment, a MET response was witnessed to be timely and attended by appropriate staff.

There is a national approach to governance over mandatory training and records were up-to-date and well managed.

The family escalation process utilises both ‘Ryan’s Rule’ and REACH. Consumer feedback on the BPH Escalation of Care brochure provided has resulted in it being reviewed and refreshed as part of a quality project. Further future evaluation of this new brochure would be encouraged to continue the quality cycle. There are adequate brochures and information for consumers for Standard 8 including but not exclusive of delirium information, REACH/escalation of care.

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:

BPH uses appropriately designed charts to assist the staff to monitor the signs of deterioration. Human factors are incorporated into acute charts and the charts have a visual prompt to escalate care when the parameters fall outside the accepted range. Audits provided evidence that there was good compliance with vital sign recording and MR-Resus Resuscitation Alerts.

There is a process to monitor and assess risk of mental state deterioration including the implementation of the 4AT assessment form. It is suggested that deterioration in cognitive impairment and use of the 4AT assessment process become part of regular auditing going forward. There are clear processes and polices for patients with deteriorating mental states and Damascus Unit in particular, has developed quick reference flow charts. Psychiatrist support is available.

BPH is using Ryan's Rule / REACH for the patients, families, or carers to escalate concerns. The use of this system is monitored and there have been few instances of this system being used. It is suggested that BPH will need to review the local strategies to engage and educate consumers and staff in this system.

There are clear policies and processes outlined for staff guidance on escalation of care and last year a survey was completed on workforce attitudes to Rapid response. Evaluation of this has led to a focus on documentation and role designation in codes.

Suggestions for Improvement:

BPH review the local strategies to engage and educate consumers on the use of Ryan's Rule / REACH.

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	

<u>Assessment Team Summary:</u>

BPH has appropriately configured ICU teams to respond to the calls for escalation of care. Responses to deterioration are currently monitored through data collected and reviewed by the rapid response group. When necessary, the patients are referred to tertiary centres by via ambulance or the using the most appropriate means of transport. BPH has processes and relationships with tertiary centres in Brisbane to facilitate rapid transfer of patients who require a higher level of care than can be provided.

Good relationships established with VMOs have resulted in timely responses and a low risk appetite for deterioration. This has been reflected in good patient outcomes and a low threshold to call for additional support for clinical review.

BPH has excellent numbers of Advanced Life Support (ALS) trained staff considering the size of the hospital. Mandatory training numbers for Basic Life Support (BLS) and PLS were also very good. It is suggested that BPH also continue to work on education plans for cognitive impairment to ensure there is a good understanding of the deteriorating mental health/cognitive status of the patient.

Recommendations from Current Assessment

Standard 1

Organisation: All facilities under membership
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

Recommendation:
BPH seek direction from the Governing Body in relation to Aboriginal and Torres Strait Islander health priorities and confirm that those measures that are developed following the expiration of the Healthscope Reconciliation Action Plan May 2019 - May 2020 fully comply with the intent of the six Aboriginal and Torres Strait Islander actions in the National Safety and Quality Health Service Standards.

Organisation: All facilities under membership
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

Recommendation:
Undertake a detailed review of the data available to Brisbane Private Hospital and Healthscope in order to:
1. Identify any specific health service needs, gaps or clinical risks specific to Aboriginal and Torres Strait Islander consumers of BPH.
2. Develop, implement and monitor a plan with strategies to address any specific Aboriginal and Torres Strait Islander health service needs identified.

Organisation: All facilities under membership
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

Recommendation:
Refer to Recommendation in 3.12 As a matter of priority; a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to:
1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards.
2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed.
3. Increase staff and patient safety through the provision of a safer environment.
4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.

Organisation: All facilities under membership
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

Recommendation:
In liaison with consumers, review the wayfinding signage and directions for Brisbane Private Hospital to ensure that they are clear and fit for purpose.

Organisation: All facilities under membership
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

Recommendation:
Continue to work with local Aboriginal and Torres Strait Islander communities to identify and develop a welcoming environment for Aboriginal and Torres Strait Islander peoples.

Standard 2

Organisation: All facilities under membership
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

Recommendation:
Brisbane Private Hospital evaluate the expired BPH Consumer Engagement Plan and develop, implement and monitor a replacement which includes how the organisation will sustain the Consumer Consultant Program.

Organisation: All facilities under membership
Action 2.13 : The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Recommendation:
Consult with local Aboriginal and Torres Strait Islander communities to develop and implement the plan outlined at Action 1.4.

Standard 3

Organisation: All facilities under membership
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

Recommendation:
As a matter of priority, a full risk assessment be undertaken including an independent Occupational Health and Safety review, plus an Infection Control review of the Endoscopy Suite to:
1. Determine the full impact of the issues with the build and equipment in this area in relation to compliance with current workplace health and safety and infection control legislation/standards.
2. Investigate how best to reduce the risk of cross contamination in the current circumstances until the planned refurbishments are completed.

3. Increase staff and patient safety through the provision of a safer environment.
4. Develop, implement and monitor an implementation plan with timelines to address the identified issues.

Organisation: All facilities under membership
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

Recommendation:
As a requirement of the Advisory 18/07 Version 6.0, 1. a Gap analysis be completed for Endoscopy by June 2021, 2. an implementation plan be developed, documented and endorsed by Executive by December 2021, 3. the plan be progressed to be completed by December 2023 according to the Advisory 18/07.

Standard 5

Organisation: All facilities under membership
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

Recommendation:
The templates for undertaking Comprehensive Care plans in the Damascus Unit be developed and endorsed in a timely manner to provide purposeful, individualised patient care that is targeted at the primary diagnosis.

Organisation: All facilities under membership
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

Recommendation:
A comparative review be undertaken of current practice for the management of falls at Brisbane Private Hospital against the best practice guidelines provided by the Safety Commission: Preventing Falls and Harm from Falling. Particular attention should be focused on flagging alerts.

Standard 6

Organisation: All facilities under membership
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

Recommendation:
1. The language in the policy and audit tools used for 'timeout' be aligned with clear definitions and education be provided to facilitate compliance.

2. The ‘timeout’ process in all theatres and procedure room fully comply with the intent of the policy which is measured by a revised audit tool.

Rating Summary

Brisbane Private Hospital

Health Service Facility ID: 101148

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met with Recommendation
1.3	Met
1.4	Not 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	Not Met
1.30	Met
1.31	Met with Recommendation
1.32	Met
1.33	Met with Recommendation

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 with Recommendation
2.12	Met
2.13	Not Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met with Recommendation

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 with Recommendation
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 with Recommendation
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met with Recommendation

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

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

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Nil